PATIENT FORM

So that we may become better acquainted, please complete both sides of this form. Your answers to the following questions will be helpful in selecting the safest and most effective means of providing orthodontic care. All information will be kept completely confidential.

Patient Information

Patient's Full Name _____Date of Birth_____

Name of school patient attends (if applicable)_____

Have any of the patient's relatives attended our surgery? _____Name of relative_____

General Dentist: _____Medical Practitioner's Name (Doctor):_____

Is the patient covered by health insurance? _____ If so, name of fund _____

Medical History

Has the patient experienced any health problems? No ☐ Yes ☐ Explain _____

Any major change in the patient's health recently? No ☐ Yes ☐ Explain _____

Is the patient currently taking medications? No ☐ Yes ☐ Explain _____

Has the patient ever been hospitalised? No ☐ Yes ☐ Explain _____

Have the patient's tonsils/adenoids been removed? No ☐ Yes ☐ Explain _____

Does the patient have any physical or mental impairment? No ☐ Yes ☐ Explain _____

Has the patient ever received speech therapy? No ☐ Yes ☐ Explain_____

Please tick if the patient has a history of any of the following conditions:

☐ Heart Murmur	☐ Haemophilia	☐ Tonsillitis	☐ Prolonged Bleeding
☐ Heart Surgery	☐ Blood Disease	☐ Frequent Headaches	☐ Hives/Rash
☐ Rheumatic Fever	☐ Arthritis	☐ Bone Disorders	☐ Drug Addiction
☐ Mitral Valve Prolapse	☐ Diabetes	☐ Developmental Disorders	☐ Nervous/Anxious
☐ Congenital Heart Disease	☐ Kidney Disease	☐ Mouth Breather	☐ Tuberculosis
☐ Endocrine Disorders	☐ Thyroid Problems	☐ Herpes (Fever Blisters)	☐ Fainting Episodes
☐ Growth Disorders	☐ Cancer	☐ Allergies	☐ Hepatitis (C)
☐ Liver Disease	☐ AIDS	☐ H.I.V. Positive	☐ Hepatitis (B)
☐ Hay Fever	☐ Epilepsy	☐ Asthma	☐ Hepatitis (A)

Does the patient clench/grind his/her teeth? No ☐ Yes ☐ When? _____

Does the patient have a nail biting habit? No ☐ Yes ☐

Does the patient suck thumb or fingers? No ☐ Yes ☐ If stopped, at what age? _____

Has the patient ever had:

Jaw/joint pain?	No ☐ Yes ☐	Jaw/joint locking?	No ☐ Yes ☐
Jaw/joint grating noises?	No ☐ Yes ☐	Jaw/joint clicking?	No ☐ Yes ☐
Jaw/joint popping?	No ☐ Yes ☐	Ringing in ears?	No ☐ Yes ☐

Since diagnostic x-rays may be indicated, in the case of a female patient, is there presently a possibility of pregnancy? No ☐ Yes ☐

PLEASE TURN OVER

PARENTS ACCOUNT INFORMATION

Parent's Marital Status: Married □ Separated □ Divorced □ Widowed □

Father's Name: _____

Address: _____

Contact Number: _____

Email Address: _____

Mother's Name: _____

Address: _____

Contact Number: _____

Email Address: _____

Person/s responsible for account:

Name: _____ Contact Number: _____

Address: _____Sign: _____

Name: _____ Contact Number: _____

Address: _____ Sign: _____

If only one person has been specified to be responsible for the account, do you give permission for Menai Orthodontics to discuss the account with another involved paying party or other parent

Yes □ No □ If yes, who _____ Sign: _____ Date _____

Due to privacy laws, Menai Orthodontics will not disclose any financial information to any person who is not named on this account information form.

I certify that the above medical and personal information is accurate at this time. If there are future changes, I will inform this office. I also authorise this office to explore and initiate necessary dental services in the case of a minor patient.

Signature: _____ Date: _____
Parent/Guardian

PLEASE NOTE: The fee for Orthodontic consultation is $75.00. If required, a panoramic full mouth X-ray $50.00 and/or a cephalometric X-ray $50.00.
In the case of a default in the payment of your account, the responsible party shall indemnify the Doctor from, and against, all costs and disbursements incurred by the Doctor in pursuing the debt, including legal costs and the Doctor's collection agency costs.

If any account remains overdue after thirty (30) days, then an amount of $5.00 shall be levied for administration fees, the sum of which shall become immediately due and payable.

Web Consent
We request permission for your child's photo/image to be published in presentations to be used by Menai Orthodontics for teaching and marketing purposes. Please sign below if you grant permission of your son/daughters image to be used by the practice.

✎ I/We grant permission for our SON/DAUGHTER's photo/image to be published in presentations to be used by Menai Orthodontics for teaching and marketing purposes.

Signature: _____ Date:_____
Parent/Guardian