SCOPE
Orthodontics

21 Coolibah Drive Greenwood
PO Box 133 Greenwood WA 6924

TELEPHONE: 9448 4244
E: info@scopeorthodontics.com.au
W: scopeorthodontics.com.au

PATIENT DETAILS (TO BE COMPLETED BY A PARENT / GUARDIAN IF THE PATIENT IS UNDER 18 YEARS OF AGE)

In order to provide you with the highest standard of orthodontic care, it is important to know the patients medical and dental history, as these could affect the success of the treatment. If you have any questions associated with the information we collect from you and hold in your records please do not hesitate to ask us. We are acting in your best interest at all times. Please read our privacy policy-"We Respect Your Privacy" for further information.

Patient

Title _____ **Last Name** _____ **First Name** _____

Home address _____ **Postcode** _____

Date of Birth _____ **Gender** _____ **School (if applicable)** _____

Email address _____

Name of person completing this form _____

Relationship to patient _____

Signature _____ **Date** _____

Name/s of any other family members who have attended the practice _____

What is your main reason for seeking this consultation _____

Whom may we thank for your referral _____

Name of your general dentist _____

Practice Name/Location _____

For the Parent/Guardian

Parent 1: _____ Phone No _____

Parent 2: _____ Phone No _____

Guardian: _____ Phone No _____

PERSON RESPONSIBLE FINANCIALLY

Title _____ First _____ Last _____ Date of Birth _____

Address _____

Phone No _____ Signature _____

Private Health Fund (if applicable) _____

Email address (if different from above) _____

PATIENT - MEDICAL AND DENTAL HISTORY – please indicate if you have confidential information that you want to discuss with the Orthodontist and not record on this form. ☐ Yes ☐ No

Has your child commenced puberty? ☐ Yes ☐ No

Has the patient inherited any facial or dental characteristics? If yes, please detail _____

Does the patient take any daily medication? (Including prescribed, over the counter or naturopathic/herbal)?

If yes, please detail _____

Any allergy to any medicines, chemicals or other substances (rubber,latex,antibiotics,peanuts etc)? ☐ Yes ☐ No

If yes, please detail _____

Please tick ONLY if the patient has, or has ever had, any of the following medical conditions

☐ Heart Disease or complaint	☐ Arthritis	☐ Mouth breathing due to nasal obstruction
☐ Heart murmur / Rheumatic Fever	☐ Liver problems	☐ High or low blood pressure
☐ ADHD	☐ Kidney problems	☐ Anaemia, Leukaemia or other blood disorders
☐ Epilepsy	☐ Bleeding problems	☐ Lung disease
☐ Asthma	☐ Speech & hearing problems	☐ Autism Spectrum Disorder
☐ Diabetes	☐ Tonsils removed	☐ Contact with AIDS (HIV) virus
☐ Hepatitis A, B or C	☐ Adenoids removed	☐ Cerebral Palsy

Any other conditions which may affect ability to undertake orthodontic treatment (please list)

Has the patient

Had any significant health problems in the past? If yes please detail _____

Any current health problems? If yes please detail _____

Any behavioural concerns that may preclude orthodontic treatment? ☐ Yes ☐ No

Had an orthodontic consultation previously? ☐ Yes ☐ No

Had any orthodontic treatment previously? If yes, please give details _____

Had an injury to the primary or permanent teeth? If yes, please give details _____

Had an injury to the face, jaws or chin? If yes, please give details _____

Has the patient ever

Sucked his/her thumb or finger, or similar habit? ☐ Yes ☐ No

Experienced clicking, popping or grating sound from the jaw joint? ☐ Yes ☐ No

Experienced pain from the jaw joints or facial muscles? ☐ Yes ☐ No