KN ORTHODONTICS

MEDICAL / DENTAL HISTORY FORM

Patient information

Mr. Mrs. Ms. Miss. Master. Other_____ Gender _____ Date of Birth _____/_____/_____

Surname _____ First Name_____ Preferred Name_____

Address _____

Suburb _____ Post Code _____ Phone_____

School / University / Occupation _____

Family Dentist Name or Dental Practice _____

Do you have a referral? **NO / YES** (if yes, list here) _____

Have you had X-Rays taken of your teeth? **NO / YES** (if yes, list company here) _____

Do you have a health fund? (E.g. Medibank, Bupa, HCF) **NO / YES** (if yes, please list here) _____

How did you hear about us: DENTIST / SCHOOL / WEBSITE / FAMILY / FRIEND

Other_____

Account details

(the person responsible for payments)

Mr. Mrs. Ms. Miss. Other_____ Name _____ Relationship _____

Email Address _____

Address_____

Suburb_____ Post Code _____

Account Person's Phone _____

Medical History

Any current illness/s? **NO / YES** (if yes, list here) _____

Any current medication/s? **NO / YES** (if yes, list here) _____

Any allergies? **NO / YES** (if yes, list here) _____

Developmental Considerations? **NO / YES** (if yes, list here) _____

PLEASE TICK

Heart Disorder / Disease	NO ☐	YES ☐	Major illness or disabilities	NO ☐	YES ☐
Heart Murmur	NO ☐	YES ☐	Speech or hearing difficulties	NO ☐	YES ☐
High or Low Blood Pressure	NO ☐	YES ☐	Contact with HIV / AIDS virus	NO ☐	YES ☐
Rheumatic Fever	NO ☐	YES ☐	Asthma	NO ☐	YES ☐
Prolonged bleeding due to injury	NO ☐	YES ☐	Hepatitis	NO ☐	YES ☐
Diabetes	NO ☐	YES ☐	Do you need antibiotic cover for dental treatment	NO ☐	YES ☐
Epilepsy	NO ☐	YES ☐			

PLEASE TURN OVER

We respect your privacy

In order to provide you with the highest standard of dental care, this practice is required to collect personal information from you. This information covers the basic details such as your name, address and telephone number but it also necessary for the orthodontist to obtain from you details regarding your general health and past medical history or surgical events. Without this general health picture, the treating orthodontist is unable to plan your care properly.

Naturally, some of this information is of a personal nature and some of it might be regarded as 'sensitive' and not the sort of information that you would wish to be unnecessarily disclosed to others.

We value the need to safeguard this information and, in accordance with the principles laid down in privacy legislation and the guidelines issued by the Australian Dental Association, we would like to assure you that:

- This information will only be used by the treating practitioner in order to deliver your care to the highest standards
- It will not be disclosed to those not associated with your treatment, without your express consent
- You may seek access to the information held about you. This access might be by inspection of your dental records at the time of appointment or by special access or copying of information at other times
- There will be no charge made for requesting this information but there may be fees levied to cover the costs associated with the processing of the request of the copying of information
- We will take reasonable steps to ensure at all times that the details we keep about you are accurate, complete and up-to-date
- We will take reasonable steps to protect this information from misuse or loss and from unauthorized access, modification or disclosure
- Our staff are trained to respect these principles at all times

If you have any questions regarding the information we collect from you and hold in your records, please do not hesitate to ask us. We are acting in your interests at all times

I certify that the above information is correct and I have read and accepted the privacy policy. I will advise the orthodontist of any changes to the above information.

Signed_____ Date _____

(parent or guardian if patient is under 18 years)