ORTHO CO.

SPECIALIST ORTHODONTISTS

PATIENT DETAILS

Title:	**Patient's First Name:**		**Nickname:**
Surname:			**Occupation:**
Date of Birth:	**Age:**	**Sex:**	**School & Year:**
Home Address:		**Suburb:**	**Postcode:**
E-mail:		**Mobile No:**	**Home No:**
Family Dentist: **Date of Last Check Up:**		**Health Fund:**	**Medical Practitioner:**
What are your main concerns regarding your teeth or jaw?			
Whom may we thank for referring you to our practice?			**How did you hear about our practice?**
Have you had family or friends treated in this practice? ☐		If YES what is their name?	
Is the Patient over 18 years of age?	☐ **Yes** (Go to Medical History)	☐ **No** (Go to Account Responsibility)	

ACCOUNT RESPONSIBILITY

To be completed by the Patient's Parent / Guardian / Responsible Party

Title:	**First Name:**	**Last Name:**
Relationship to Patient:		
Are your contact details the same as the Patient Details noted above?	☐ **Yes** (Go to Medical History)	☐ **No** (Please enter only the **differences** below)
Home Address: **Postcode:**		**Suburb:**
Email Address:		**Mobile No:** **Home No:**

MEDICAL HISTORY: Do you have or ever had any of the following?

	Yes	No		Yes	No
Allergy to Latex	☐	☐	Asthma	☐	☐
Congenital heart disease or Rheumatic fever	☐	☐	Epilepsy/Diabetes	☐	☐
Heart or Kidney Disease	☐	☐	Ulcers / Cold Sores / Herpes (any type)	☐	☐
Hepatitis or HIV	☐	☐	Chance of Pregnancy	☐	☐
Asperger's, Autism, ADD, ADHD (Circle if Yes)	☐	☐	Do you require antibiotic cover for dental procedures	☐	☐
Allergies (Please list if YES)	☐	☐			

Please note any other significant information about your medical history, including **current medications & serious operations**

Have you ever had your tonsils and/or adenoids removed? When? ☐ ☐

Please Turn Page ⟶

CHILD SLEEP QUESTIONNAIRE

Complete if Patient is 16 years and under

Consider each question over the **past 6 months**. Please circle the number 1 to 5.

	1 **Never**	2 **Occasionally (once or twice per month or less)**	3 **Sometimes (once or twice per week)**	4 **Often (3 or 5 times per week)**	5 **Always (daily)**
The child has difficulty in breathing during the night	1	2	3	4	5
The child gasps for breath or is unable to breathe during sleep	1	2	3	4	5
The child snores	1	2	3	4	5

ADULT SLEEP QUESTIONNAIRE

Complete if Patient is 17 years and older

Use the following scale to choose the most appropriate number for each situation.

0 = would **never** doze or sleep 1= **slight** chance of dozing or sleeping 2 = **moderate** chance of dozing or sleeping 4 = **high** chance of dozing or sleeping

SITUATION	**CHANCE OF DOZING OR SLEEPING 0 TO 4 (see above scale)**
Sitting and reading	
Watching TV	
Sitting inactive in a public space	
Being a passenger in a motor vehicle for an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped for a few minutes in traffic while driving	

DENTAL HISTORY:

Do you have or have you ever had any of the following?	**Yes**	**No**
Painful teeth? If yes, ☐ upper right ☐ upper left ☐ lower right ☐ lower left	☐	☐
Have any teeth been removed? How many?	☐	☐
Do you have or have you had any of the following habits - Finger or Thumb sucking / Lip Biting / Nail Biting	☐	☐
Have you ever had an accident involving teeth, chin or jaw? If yes, describe	☐	☐
Do you clench or grind their teeth? If yes, ☐ while sleeping ☐ under stress other ……	☐	☐
Have you ever had clicking, noises, or pain in your jaw joints? If yes describe,	☐	☐
Have you had previous orthodontic treatment? If yes, when and name of practitioner?	☐	☐

INTERESTS AND ACTIVITIES

Hobbies:

For Children: Any information you can give me concerning your child will be appreciated. It is important that I am aware of any behavioural or schooling difficulties, and any upsetting dental experiences

YOUR HEALTH INFORMATION AND OUR PRIVACY POLICY - Our practice respects your right to privacy. More detailed information is set out in our Privacy Policy on our website: www.orthoco.com.au. The information we collect will be used for the purpose of providing treatment to you. Unless you tell us you do not want to receive information from us, we will use these details to keep you updated about our services. We may also use parts of your health information for staff training, professional development and dental health research. Your personal identity will not be disclosed without your consent to do so. Your clinical information including records are may be kept in both a written form and in electronic clinical information systems. We have security measures in place to protect this information against unauthorised access, theft or other loss. We may use contracted external providers to assist us with this data storage, these providers are based in Australia. You may inspect or request copies of your treatment records at any time, if you want copies, a fee may apply. It is important that the information we hold about you remains accurate. Please advise our staff if your contact or medical details ever change. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

CONSENT TO DENTAL PHOTOGRAPHY- I, authorize Dr. Doreen Ng and Ortho Co., to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment. I consent to allow the photographs to be used for the following: dental records, education and research including lectures, professional publications, marketing material, including websites and printed materials, social media, patient education. I further understand that if the photographs and/or videos are used, Ortho Co. will make all reasonable effort to safeguard your privacy and to conceal your identity if requested. I do not expect compensation, financial or otherwise, for the use of these photographs and relinquish any and all rights to the any images of me obtained by any photographic or digital means by Ortho Co.

☐ Tick here if you do not want your full-face photos used for any of the above purposes.

Signature of Responsible Party _____ **Date** / /