PATIENT DETAILS AND HISTORY FORM

Title (circle) Dr/Mr/Mrs/Miss/Ms/Master	Given name/s
Surname	Preferred name
Address	Suburb Postcode
	Email address
Telephone H W	M
Occupation	School/University name
Marital status Date of Birth / /	Age Gender (circle) M / F
Mother's full name	Father's full name
How did you find out about us? (circle) Family/Friend/Dentist/Yellow Pages/Internet/Other, please specify:	
Person responsible for account (circle) Dr/Mr/Mrs/Miss/Ms	Relationship to the patient
First Name	Surname
Address	Suburb Postcode
Email address	
Telephone H W	M
Second person responsible for account Name/s	Address Contact no.
Emergency Contact (circle) Dr/Mr/Mrs/Miss/Ms/Master	Relationship to the patient
First name	Surname
Address	Suburb Postcode
Telephone H W	M
Regular Dentist Name	Contact no.
Address	Suburb Postcode
Regular Doctor Name	Contact no.
Address	Suburb Postcode
Private Health Insurance (circle) Y / N	Health Fund Name

DENTAL AND MEDICAL HISTORY

Have you had your teeth checked in the last 12 months? Please provide date:	(circle) Y / N
Have you been to see another Orthodontist?	Y / N
Are you currently having orthodontic treatment?	Y / N
Have you undergone orthodontic treatment in the past?	Y / N
Have any other members of your family had orthodontic treatment and where?	Y / N
Do you have any brothers or sisters? If so, how many? Brothers? Sisters? Are you a twin?	Y / N
Have your teeth or jaws ever been damaged in an accident?	Y / N
Do you ever suffer from pain, clicking, limitation of movement or locking of your jaw joints?	Y / N
Injuries to teeth or face? Y / N — Thumb/Finger sucking?	Y / N
Mouth breathing? Y / N — Teeth grinding?	Y / N
Extra or missing teeth? Y / N — Past injuries to face, teeth or jaws?	Y / N
What is your main concern about your teeth/bite?	
Have you ever had a serious medical or surgical problem? Please explain:	Y / N
Have you taken antibiotics for a period longer than three months?	Y / N
Are you currently on any medications? Please list:	Y / N
Do you have any allergies (food or drugs/medications)? Please list:	Y / N
(Females only) Are you pregnant?	Y / N

Have you or do you suffer from any of the following? If Yes, please circle:

a) Rheumatic Fever	b) Heart disease	c) High/Low blood pressure	d) Stroke
e) Rheumatism	f) Asthma	g) Diabetes	h) Fits/Epilepsy
i) Kidney Disease	j) Hepatitis	k) Endocrine problems	l) Cold sores/Herpes
m) Tonsil removal	n) Adenoid removal	o) Excessive bleeding	p) Bone Disorder

Do you have or are you at high risk to AIDS or Hepatitis B? If Yes, please advise the doctor in the consultation. Y / N

Details on those selected above or any further information?

Print name/s	Sign	Date
Parent/guardian if patient less than 18 years of age Name/s	Sign	Date

SABLE AND PEPICELLI ORTHODONTISTS

YOUR CONSENT FOR X-RAYS (MEDICARE)

Please fill in information and sign below as confirmation of consent to x-rays being taken during orthodontic treatment.

Patient Medicare number: _ _ _ _ _ _ _ _ _ _ _ _#_		Expiry date:_ _ /_ _
Print name/s	Sign	Date
Parent/guardian if patient less than 18 years of age Name/s	Sign	Date

YOUR HEALTH INFORMATION PRIVACY CONSENT FORM

Our practice respects your right to privacy. We realise that it is important that you understand the purpose for which we collect details about your health and how this information is used at this practice and to whom the information may be disclosed.

The policy of this practice is to follow these procedures:

1. The information you provide us will be used for the purpose of providing treatment to you. Personal information such as your name, address and health insurance details will be used for the purpose of addressing accounts to you, as well as processing payments and writing to you about our services and any issues affecting your treatment.

2. We may disclose your health information (communications, images, x-rays) to other health care professionals, or require it from them if, in our judgment, it is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimised where possible. This would occur via mail or email between the health care professionals.

3. We may also use parts of your health information for research purposes, in study groups or at seminars as this may provide benefit to other patients. Should that happen, your personal identity will not be disclosed without your consent to do so.

4. Your medical history, treatment records, x-rays and other material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time, or seek an explanation from the orthodontist. Statutory fees will apply in relation to the type of access you seek. If you request an explanation of our records or a written summary, our usual fees apply to these services.

5. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

You can otherwise rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without prior written consent. 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.

Please sign this form as confirmation that you have read and understand our privacy policy, and consent to the use of your health information as outlined above.

Print name/s	**Sign**	**Date**
…………………………………………	………………………………	………………………
Print name/s	**Sign**	**Date**
…………………………………………	………………………………	………………………

Parent/guardian if patient less than 18 years of age

Dr Andrew Pepicelli BDSc, MDSc, Grad Dip Clin Dent, MOrth RCS (Ed) | Dr Daniel Sable BPharm, BDSc, MDSc, Grad Dip Clin Dent | Dr Anna Meyer BDS (Otago), DCD (Melb), MOrth RCS (Ed), MRACDS (Orth)

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