PATIENT DETAILS AND HISTORY FORM

Title: Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Master ☐	**Date of birth: / / Age: Gender:**
Given Name/s:	Surname:
Address: Suburb: Postcode:	Phone: Email:
First Parent/Guardian Name:	Second Parent/Guardian Name:

Person responsible for this account	Relationship to the patient:
Title: Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐	Full Name:
Address: Suburb: Postcode:	Phone Email:
Second person responsible for this account ***(if applicable)***	Relationship to the patient:
Title: Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐	Full Name:
Address: Suburb: Postcode:	Phone: Email:

Emergency Contact	Relationship to the patient:
Full name:	Contact phone:

Regular Dentist Name:	Address:
Phone:	Suburb: Postcode:
Regular Doctor Name:	Address:
Phone:	Suburb: Postcode:

What is your main concern about your teeth/bite?

DENTAL AND MEDICAL HISTORY			
Have you had your teeth checked in the last 12 months?			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☐
Have you ever suffered an injury to your teeth or jaws?			Y☐ N☐
Do you ever suffer from any jaw joint related issues (e.g. pain, clicking, locking, limited jaw movement)?			Y☐ N☐
Teeth grinding/clenching?			Y☐ N☐
Thumb/finger sucking habit (now or in the past)?			Y☐ N☐
Mouth breathing?			Y☐ N☐
Extra or missing teeth?			Y☐ N☐
Have you taken antibiotics for a period longer than three months?			Y☐ N☐
(Females only) Are you pregnant?			Y☐ N☐
Do you have any siblings? If so, how many?	Brothers	Sisters	Are you a Twin?
Please list all current medications:			
Please list any allergies (food or drugs/medication):			

Have you or do you suffer from any of the following?

☐ Rheumatic Fever	☐ Heart conditions	☐ High/Low blood pressure	☐ Stroke
☐ Rheumatism	☐ Asthma	☐ Diabetes	☐ Fits/Epilepsy
☐ Kidney/Liver disease	☐ Hepatitis/HIV	☐ Endocrine problems	☐ Cold sores/Herpes
☐ Blood-borne disease	☐ Adenoid removal	☐ Excessive bleeding	☐ Bone Disorder
☐ Tonsil removal	☐ Snoring/Sleep apnea	☐ Other	

Print Name (Parent/guardian if patient less than 18 years of age)	**Sign**	**Date**
....	....	....

Dr Andrew Pepicelli BDSc, MDSc, Grad Dip Clin Dent, MOrth RCS (Ed) | Dr Daniel Sable BPharm, BDSc, MDSc, Grad Dip Clin Dent | Dr James Newby BDSc (Hons), DCD
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SABLE AND PEPICELLI ORTHODONTISTS

HOW DID YOU HEAR ABOUT SABLE AND PEPICELLI ORTHODONTISTS?

☐ Dentist ☐ Family ☐ Friend ☐ Internet ☐ Yellow Pages

☐ Other (please list): …….....

YOUR CONSENT FOR X-RAYS AND PHOTOGRAPHS

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

Print Name (Parent/guardian if patient less than 18 years of age)	**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 (Parent/guardian if patient less than 18 years of age)	**Sign**	**Date**
…………………………………………………………	……………………………	………………………