wilkinson orthodontics

PATIENT MEDICAL HISTORY

Dental Practice ACCREDITED

Patient Details:

First Name: _____ Last Name: _____ D.O.B:____/____/_____
Address: _____
Please complete if Patient is under 18 years old:
School: _____Grade:_____
Mother's Name:_____ Telephone:_____
Father's Name:_____ Telephone:_____
Sibling(s) Name & Age: _____

Billing Details:

Name of the person responsible for the Account: (one name only) _____
Address: _____
Telephone: (Home)_____ (Work)_____(Mobile)_____
Email: _____

Dental History:

General Dentist:_____ Date of last Check and Clean:_____
Private Health Insurance Provider: _____
Has the patient inherited any family dental characteristics? _____
Any major falls, accidents or operations involving the mouth area? _____
What is your main concern in seeking this consultation?_____

Has/Does the patient suck their thumb or fingers?	Yes / No
Does the patient clench / grind their teeth at night	Yes / No
Does the patient have any difficulty breathing through the nose?	Yes / No
Has the patient had any previous orthodontic treatment?	Yes / No

Medical History:

Is the patient under the care of a medical practitioner? (Name and reason)_____
Is the patient taking any medication? (Please list) _____
Has the patient had/have any of the following?

- ☐ Severe chest pain
- ☐ Heart disorder of any kind
  Type: _____
  Is antibiotic cover required Yes / No
- ☐ High / Low blood pressure (circle)
- ☐ Rheumatic fever
- ☐ Shortness of breath
- ☐ Frequent dizziness
- ☐ Prolonged bleeding / Haemophilia
- ☐ Blood transfusion
- ☐ Allergy to Latex
- ☐ Anaemia
- ☐ Bronchitis (in last 6 months)
- ☐ Is the patient pregnant?
  How many weeks: _____
- ☐ Asthma
- ☐ Jaundice or Liver disease
- ☐ Hepatitis.
  Type: _____
- ☐ Gland disorders:
  Type: _____
- ☐ Epilepsy
- ☐ Arthritis
- ☐ HIV/AIDS Virus (circle)
- ☐ Treatment of cancer
  Type: _____
- ☐ Tonsils or Adenoids removed (circle)
- ☐ Allergies to medications
  _____
- ☐ Syndromes or disorders (please specify eg: ADHD)
  _____

☐ **Please tick if none of the above apply**

Please let the staff know if there are any medical concerns that you would like to discuss with the doctor in private

ALL INFORMATION WILL BE TREATED WITH COMPLETE PROFESSIONAL CONFIDENTIALITY

I ACKNOWLEDGE AND CONSENT TO THE PRIVACY DOCUMENT OVERLEAF

Signature of person completing this form: _____Date: _____/_____/_____
PLEASE PRINT NAME: _____ **RELATIONSHIP TO PATIENT:** _____
Whom may we thank for referring you? _____

Continued overleaf...

wilkinson orthodontics

Dental Practice QIP Quality Innovation Performance ACCREDITED

ADA Queensland

We Respect Your Privacy

In order to provide you with the highest standard of dental care, this is required to collect personal information from you. This information covers basic details such as your name, address and telephone numbers but it is also necessary for the dentist to obtain from you details regarding your general health and past medical or surgical events. Without this general health picture, the treating dentist 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 dentist 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 and we will provide this access without delay. 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 just to cover the costs associated with the processing of this 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 dental records, please do not hesitate to ask us. We are acting in your interests at all times.

ALL INFORMATION WILL BE TREATED WITH COMPLETE PROFESSIONAL CONFIDENTIALITY

- I acknowledge and consent to Wilkinson Orthodontics electronically transferring radiographs and medical history/details to consulting dentists and specialists in the course of my treatment if so required by Wilkinson Orthodontics.
- I acknowledge and consent to Wilkinson Orthodontics electronically storing my medical information and contracts; and that the original/hard copies may be destroyed once digitally copied if so required by Wilkinson Orthodontics.
- Wilkinson Orthodontics can use my personal data to contact me by electronic means (e-mail or SMS) with information about goods and services from Wilkinson Orthodontics.