Health Fund

_____

Hanks orthodontics
MAKING THE PENINSULA SMILE

Medical and Dental History

Patient Information

Date form completed _____

Patient: Mr/Mst/Mrs/Ms /Dr Surname _____ Given Names _____

Preferred Name _____ Date of Birth ____ /____ /____ Age _____ Marital Status _____

Street Address _____ Suburb _____ Post Code _____

Contact Tel (H) _____ (W) _____ (Mob) _____

Occupation _____ Person to Notify in Case of Emergency _____

General Dental Practitioner

Name _____ Last Seen _____ Time registered _____

General Medical Practitioner

Name _____ Address _____

Referral

Who referred you to us? circle ○ Dentist ○ Family ○ Friend ○ Our staff ○ Our patient ○ Self ○ Website

Name _____

For patients under 18

School/Campus _____

Person Paying Account circle ○ Mother (M) ○ Father (F) or ○ Other ….Given Name _____ Surname _____

Father Name _____ Ph: _____ Email _____

Mother Name _____ Ph: _____ Email _____

Street Address (D) _____ Suburb _____ Post Code _____
(If different from patient)

Street Address (M) _____ Suburb _____ Post Code _____
(If different from patient)

Medical Information

	Yes	No	
Is the patient in good health?	☐	☐	
Is the patient under the care of a physician?	☐	☐	If so, explain _____
Presently taking any medication?	☐	☐	If so, explain _____

(Please check yes or no if you have ever had any of the following)

Y	N		Y	N		Y	N		Y	N	
☐	☐	Frequent Colds	☐	☐	Allergies	☐	☐	Dizziness/fainting	☐	☐	Asthma
☐	☐	Rheumatoid/Arthritic problems				☐	☐	Risks for tuberculosis, AIDS, Hepatitis, HIV, Other			
☐	☐	Heart Trouble	☐	☐	Diabetes	☐	☐	Kidney/Liver disease	☐	☐	Blood Disorders
☐	☐	Epilepsy	☐	☐	Eating Disorder/Anorexia Bullemia						
☐	☐	Hearing Difficulties	☐	☐	Other _____						

Have the tonsils and adenoids been removed? _____

Dental Information (Please check yes or no if you have ever had any of the following habits)

Y	N		Y	N		Y	N		Y	N	
☐	☐	Thumb Sucking	☐	☐	Mouth Breathing	☐	☐	Grinding of Teeth	☐	☐	Tongue Biting
☐	☐	Nail Biting	☐	☐	Tongue Thrusting	☐	☐	Speech Disorders	☐	☐	Abnormal Breathing
☐	☐	Lip Biting	☐	☐	Tooth grinding/clenching	☐	☐	Jaw joint pain/stiffness	☐	☐	Difficulty with opening

(Please check yes or no if you have ever had any of the following)

Y	N		Y	N		Y	N		Y	N	
☐	☐	Chipped/knocked teeth	☐	☐	Dead/dark teeth	☐	☐	Sensitive teeth	☐	☐	Extra (supernumerary) teeth
☐	☐	Gum problems	☐	☐	Food impaction between teeth				☐	☐	Loose/broken filling
☐	☐	Gum boils / lumps in mouth				☐	☐	Lip Biting	☐	☐	Missing Teeth
☐	☐	Removal of baby teeth that were not loose				☐	☐	Bleeding gums			

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Smile Questions **(Please check the statements that apply)**

☐ My teeth are too prominent (stick out) ☐ My teeth are too long/large ☐ My teeth are too pointy
☐ My teeth are too retrusive (hard to see) ☐ My teeth are too small ☐ My teeth are off colour

Patient concerns **(Please check the statements that apply)**

☐ My teeth are too crooked ☐ I do not like smiling ☐ I have too many spaces between my teeth ☐ I show too much gum
☐ My jaw seems too small ☐ My jaw seems too big ☐ I am teased at school ☐ My bite is not right

Orthodontic Experience

	Y	N	
Have you had braces before?	☐	☐	If so, when? _____
Have you ever had another orthodontic opinion?	☐	☐	If so, explain _____

Please give name, date of birth and age of any and all other children in family:

_____

_____

_____

Have there ever been any other family members seen by Dr. Hanks? Please give names:

_____

_____

_____

Is there anything else that you feel Dr. Hanks should know regarding the patient?

_____

_____

Correspondance

In respect of the environment and to reduce usage of paper, we would prefer to send all correspondence electronically.

Please circle your preferred method: Email Post (contact address listed above)

Please circle addressee (person responsible for account) for correspondence: ☐ Mother ☐ Father ☐ Other

Health Information and Privacy Policy (in accordance with the Victorian Health Records Act 2001 and Privacy Act)

We respect the right to your privacy. We realize that it is important you understand the purpose which we collect details about your health, as well as how this information is used at our practice, and to whom this information might be disclosed. The information collected 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.

We may disclose your health information to other health care professionals, or require it from them if, in our judgement, it is necessary in the context of your treatment. In this event,, disclosure of your personal details will be minimized wherever possible.

We may use images or parts of your health information for research and educational purposes, in study groups or at patient presentations as examples of orthodontic issues and treatments that are possible, to provide benefit to other patients

Signed: _____

Print Name: _____

Date _____

E: mteliza@hanksorthodontics.com.au T: 03 9787 3849