the|ortho|practice

Please spend some time to complete all relevant details below for future correspondence to you and your dentist. **Check your details carefully to ensure we have the correct information.**

Patient Details **Pt ID:** ____________________

Surname: _______________________________ Given Name: ________________________

Preferred Name: __________________________

Please indicate: MR ☐ MRS ☐ MISS ☐ MS ☐ DR ☐ OTHER ____

Date of Birth: ____________________________ Gender identifies as: ___________________

Address: ____

Suburb: ______________________________ State: ___________________________________

Postcode: __________________________ Home Phone: _______________________

Work Phone: _______________________ Mobile: ____________________________

Email: ____

Dentist/Practice Name: ____

Please detail the orthodontic concerns that you have:

How did you hear about us?

Health Fund: ___________________________

Have you been given a referral from the dentist? Yes / No

Have any of the following X-Rays been taken in the past 12 months (please circle)?

OPG/ Lateral Cephalogram

Name of sibling / siblings who attend The Ortho Practice: _______________________________

Billing/ Responsible Party Details

Surname: ______________________________ Given Name: ________________________

Please indicate: MR ☐ MRS ☐ MISS ☐ MS ☐ DR ☐ OTHER ____

Address: ____

Suburb: ____________________________ Postcode: ____________________________

Mobile: ________________________________

Email: ____

Additional Billing/ Responsible Party Details

Surname: ______________________________ Given Name: ________________________

Please indicate: MR ☐ MRS ☐ MISS ☐ MS ☐ DR ☐ OTHER ____

Address: ____

Suburb: ____________________________ Postcode: ____________________________

Mobile: ________________________________

Email: ____

Dental History	**YES**	**NO**
Jaw discomfort when chewing?		
Does the patient grind their teeth?		
If yes, grind at night?		
If yes, grind during the day?		
Has there been a history of thumb or finger sucking?		
History of snoring?		
History of sleeping with mouth open?		
None of the above		
Any past injury/surgery to the face/teeth/jaws? Please advise nature, outcome and dates		
Date of last dental visit and the reason		
Have you seen a Periodontist (gum specialist)? Please advise nature, outcome and dates		

Medical Alerts	**YES**	**NO**
Anemia		
Anaphylaxis		
Asthma		
Bleeding disorders		
Cognitive impairment		
Diabetes		

Epilepsy		
Heart problems		
Hepatitis		
Learning difficulties		
Oral herpes/ cold sores		
Osteoporosis		
Mental health illness		
Radiotherapy/ Chemotherapy		
None of the above		
Please list the medications the patient is taking		

Medical Comments	**YES**	**NO**
Frequent headaches o neck pain		
High blood pressure		
Kidney disorders		
Lung disorders		
Rheumatic fever		
Thyroid disorders		
Tuberculosis		
Is the patient a smoker/ vaper?		
Is the patient pregnant?		
None of the above		
Any other long term infection illnesses?		

Allergies	**YES**	**NO**
Aspirin		
Dust/pollen or General hay fever		
Iodine		
Penicillin		
Sulphur		
Latex		
Nuts (please provide specific details in box below)		
Seafood (please provide specific details in box below)		
Other (please provide specific details in bow below)		
None of the above		
Please provide more information from question above		

Signed by: ____________________

Print name: ____________________

Relationship to patient (if patient is under 18 years of age): ____________________

Date: ____________________

YOUR HEALTH INFORMATION AND OUR PRIVACY POLICY

Our practice respects your right to privacy. It is important that you understand the purpose for which we collect details about you and your health, as well as how this information is used at our practice and to whom this information might be disclosed. More detailed information is set out in our Privacy Policy. If you would like a copy of the policy please ask our staff.

The information we collect will be used for the purpose of providing treatment to you. Personal information such as your name, address, telephone numbers, email address and health insurance details will also be used for the purpose of billing and processing payments. Unless you tell us you do not want to receive information from us, we will also use these details to keep you updated about our services and advise you of other products and services relevant to your dental and general health.

Unless required to do so by court order or other legislative requirement, we will only collect, use and disclose your health information for the purposes of assessing, advising and treating you. We may also use parts of your health information for staff training, professional development, quality improvement and dental health research. Your personal identity will not be disclosed without your consent to do so or, if this is not possible, with the approval of an ethics committee.

Your patient history, treatment records, x-rays and any other material relevant to your treatment are kept in both a written form and in electronic clinical information systems. Our practice is part of a larger software management, Dolphin Management Software who assist us with the management, storage and operation of our clinical information and data systems.

We have security measures in place to protect this information against unauthorised access or use and damage, theft or other loss. We may use contracted external providers to assist us with this data storage, access and use. These providers are based both in Australia and in America.

You may inspect or request copies of your treatment records at any time, or seek an explanation from the dentist. If you want copies, a fee may apply. If you require a detailed explanation of your records or a written summary, a consultation fee or other charge may apply.

It is important that the information we hold about you remains accurate. Please advise our staff if your contacts details change. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

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 below to confirm that:

1) you have read this information;
2) you agree to our collecting, using and disclosing your information in this way;

First Name: ____

Last Name: ____

Signature: ____

Date: ____