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Pt ID:_______________

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

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: ____________________________

Billing/ Responsible Party Details

Surname: ________________________________ Given Name: _________________________

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

Address: ____

Suburb: _____________________________ Postcode: ______________________________

Mobile: _________________________________

Email: ____

Pt ID:_______________

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		
Leaning difficulties		
Oral herpes/ cold sores		
Osteoporosis		
Physical disability		
Radiotherapy/ Chemotherapy		
None of the above		

Pt ID:_______________

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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: ______________________________

Pt ID:______________

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Please read this ..

Privacy Collection Statement to see how we use your personal information.

The Ortho Practice collect, handle, use and protect your personal information in accordance with the Privacy Act 1988 (Cth) and our Privacy Policy which can be viewed in full **https://mavendental.com.au/privacy-policy**. Or please ask our reception team for a copy of our Privacy Policy.

We collect your personal information to provide you with products and services you have requested, improve our products and services, keep you informed of your upcoming appointments and notify you about our latest promotions and other offers relevant to you. We collect this information mainly through our communications with you, but we may do so also from other sources in the course of providing our services to you. You are not obliged to provide us with your personal information, however this may impact our ability to provide you with our products and services. We generally do not disclose information about you to any person and will only share your personal information where necessary to provide you with products and services, as required by law, or with your permission. Our Privacy Policy sets out how you can access and change your personal information or make a privacy complaint.

If you would like us to send you a copy of our Privacy Policy, inform us that you do not wish to receive promotional material from us, request access to or the correction of information we hold about you or to make a complaint about our treatment of your privacy, please contact us by email at notices@mavendental.com.au by phone on +61 (07) 5635 2000 or by mail to The Privacy Officer, Maven Dental Group, PO Box 1146 SOUTHPORT BC QLD 4215.

First Name: ______________________________

Last Name: ______________________________

Signature: ______________________________

Date: ______________________________