AboutFace orthodontics
turn your smile around...

M E D I C A L   H I S T O R Y

Please complete the following information, which we consider strictly 'Confidential'. Please discuss any concerns you may have with our staff. 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.

Have you read or intend to read our privacy policy (www.aboutfaceortho.com.au) YES / NO

PERSONAL DETAILS

Patient's **SURNAME:** ____________________________ Patient's **FIRST NAME**:______________________________

Date of birth:__________________________________ MALE / FEMALE / OTHER

Email:_______________________________________ Current **School**:____________________________________

Mobile:______________________________________

Emergency contact Name:_______________________ Emergency Mobile:_________________________________

Mother's / Guardian name (if under 18 years age):____

Father's / Guardian name (if under 18 years age):____

Residential Address:____

Postal Address:____

HAVE YOU MET DR. STEVAN SAICICH BEFORE? YES / NO

HEALTH INSURANCE: YES / NO If yes, which fund:____

ACCOUNT DETAILS: Name of person responsible for account (signatory):____

Relationship to patient: MOTHER / FATHER / GUARDIAN

DENTIST INFORMATION FOR CORRESPONDENCE: Dentist name:____

SCHOOL DENTIST / PRIVATE DENTIST PRACTICE:____

REFERRAL SOURCE: How did you hear about our practice? DENTIST / INTERNET / FRIEND / OTHER:_____________________

CURRENT CONCERNS: Please provide a brief description of your concerns regarding your / your child's teeth:

____

Has anyone in your household returned from overseas travel in the last 10 days? **YES / NO**

Do you smoke: **YES / NO** **For female patients only,** are you pregnant: **YES / NO**

Are antibiotics required BEFORE any dental treatment: **YES / NO**

Do you know of any allergies (including drug, nickel and LATEX): **YES / NO** If yes, please list details:__________________________

Has there been any serious injuries involving the face, mouth or teeth? **YES / NO** If yes, please list details:

____

If the patient being treated by a medical practitioner for any condition at the moment? **YES / NO** If yes, please provide Medical Practitioner's name and address:____

Please list any tablets/medicines (including over-the counter and prescribed) being taken:________________________________

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MEDICAL HISTORY

PLEASE TICK IF THE PATIENT HAS HAD OR HAS ANY OF THE FOLLOWING MEDICAL CONDITIONS:

- ☐ Asthma
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Rheumatic Fever
- ☐ Excessive Bleeding
- ☐ Anemia, Leukemia or any other blood disorder
- ☐ High / Low blood pressure
- ☐ Heart Murmur
- ☐ Steroid Therapy
- ☐ Prosthetic Implant (shunt, limb)
- ☐ Cardiac Pacemaker
- ☐ Hepatitis or other Liver Disease
- ☐ Contact with AIDS/HIV or any other blood borne disease
- ☐ Tuberculosis
- ☐ Heart valve disorder
- ☐ Nervous or psychiatric conditions
- ☐ Bone disease including osteoporosis
- ☐ Stomach or digestive condition
- ☐ Abnormal reactions to local anesthetic
- ☐ Thyroid disorder
- ☐ Radiation therapy
- ☐ Bronchitis, emphysema or other lung disease

Any other conditions, please list:____

PATIENTS TRANFERRING FROM ANOTHER ORTHODONTIST – <u>Only complete if applicable</u>

Have you had any previous Orthodontic treatment? OR are you transferring from another Orthodontic practice? Is YES

***Previous Orthodontist:*___________________________________ *Email Address:*______________________________________**

By signing below, you provide consent for About Face Orthodontics to contact the above listed Orthodontist to request any records pertaining to your Orthodontic treatment.

I, _ consent to the above listed Orthodontist releasing my Dental records (including x-rays and photos) to About Face Orthodontics.

Signed: _

Date:_ _ _/_ _ _/_ _ _

PATIENT CONSENT

Declaration of consent relating to medical/dental information and examination. Due to recent changes in the Privacy Laws, a person's written consent is now required for a health professional to obtain medical information about them and be able to communicate medical information about them to another medical practitioner.

I give permission/consent for About Face Orthodontics to both obtain and liaise with other medical practitioners, including consultation notes, test results, investigation performed by other medical practitioners that pertain to my medical condition. To communicate with both the referring health professional as well as other health professionals directly involved in my medical care.

I consent to the taking of photograph and x-rays before, during and after treatment, and understand that will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations and professional publications (Website / Facebook). If photographs are used in any publication or as a part of a demonstration, full names or other identifying information will be kept confidential.

I consent to emails being used as a form of correspondence.

I consent for Dr Stevan Saicich to complete a preliminary examination for myself/child.

I declare that the information provided in this medical history is accurate at this time and that I have disclosed all relevant medical/dental history.

I understand that I should advise the Orthodontist is any of my/child's medical/dental history changes during the course of treatment.

I understand this medical/dental history and my/child's orthodontic treatment information is 'Confidential' and not made available to any other party except where governed by State of Federal Laws.

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SIGNATURE OF PARENT, GUARDIAN OR PATIENT OVER 18 YEARS OF AGE

_ _ _ _/_ _ _ _/_ _ _ _

DATE

OFFICE USE ONLY – Reviewed by: (please print name) **Signature:** **Date:**