Cairns Specialist ORTHODONTISTS
ABN: 36 606 902 158

PATIENT HISTORY FORM

Title: …….. First Name: …… Surname:

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Gender: …… Date of birth:

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Ethnic Background: (for cephalometric growth analysis)

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Residential/Postal Address:

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Phone numbers: Home: ……..……..…… Mobile: ……..……..…… Work:

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Email address:

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Do you have private health insurance? ……..…. If so which fund? ……

Emergency contact: Name: …….. Phone Number:

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What is your main reason for visiting an Orthodontist?

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If completing on behalf of your child:

Name of Mother: ……..……..…..... Contact Number:

…….....

Name of Father: ..……..... Contact Number:

……..…….....

Name of Guardian (if applicable): ……..…..... Contact Number:

……..…..…..

Patient lives with: Both parents / Father / Mother / Guardian / Self

Which school do they attend?

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DENTAL HISTORY

Name of Dentist and location of practice:

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Please answer accordingly:

	Yes	No
Have you ever had any significant dental treatment?		
Are you currently receiving ongoing dental treatment (e.g. fillings, root canal treatment)?		
Do your gums bleed when you brush?		
Do you use any added fluoride products (e.g. rinse, gel, tablets)?		
Have you ever had dental braces or an orthodontic plate before?		
Have you had any significant trauma to your teeth, chin or face?		
Do you currently or previously suck your thumb?		
Do you have problems with your jaw joints (e.g. pain, clicking, difficulty opening/closing)?		

MEDICAL HISTORY

Name of Doctor and location of practice:

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Do you have/had any of the following?

	Yes	No		Yes	No
Problems at birth			Asthma or any breathing disorder		
Growth problems			Cancer of any sort		
Cleft lip/palate			Hepatitis or any liver condition		
Heart condition			Kidney disorder		
Blood pressure ↑/↓			Allergy (including milk proteins)		
Heart murmur			Bone related disorder		
Rheumatic fever			Problems with tonsils, adenoids, sinus		
Haemophilia or any bleeding disorder			Problems with speech or hearing		
AIDS/HIV			Sleep problems or snoring		
Diabetes			Attention deficit disorder		
Arthritis			Emotional/behavioral problems		
Smoker			Women, are you pregnant		
Epilepsy or Seizures			Other		

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Have you taken any medications in the past?

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How did you hear about us?

Referred by dentist ☐ Referred by friend/relative ☐ Google/internet ☐

Facebook ☐ Other ☐

As a courtesy we confirm appointments the day prior.

How would you like to be reminded? SMS / Email

Person completing this form:

Name: ……..... Signature:

…….....

Date: ……..……..