NAME: ……

ADDRESS: ……

……

DATE OF BIRTH: ……

MOBILE (PATIENT)……

EMAIL (PATIENT)……

HOME……

WORK……

MOBILE (GUARDIAN)……

EMAIL (GUARDIAN) ……

EMERGENCY CONTACT DETAILS

……

PERSON RESPONSIBLE FOR ACCOUNTS / PAYMENT:

NAME: ……

ADDRESS: ……

……

HOME PH……

WORK PH……

MOBILE PH……

DENTIST:

NAME……

ADDRESS ……

……

PHONE……

DENTAL HISTORY

……

……

……

GENERAL PRACTITIONER:

NAME……

ADDRESS ……

……

PHONE……

REASON FOR COMING TO ORTHODONTIST

……

……

HOW DID YOU HEAR ABOUT US?

Family / Friend	
Dentist	
Internet – Google	
Internet – Yellow pages	
Telephone Book	
Newspaper	
Radio	

DO YOU HAVE ANY OF THE FOLLOWING?

HEART PROBLEMS	YES / NO
RHEUMATIC FEVER	YES / NO
BLOOD PRESSURE	YES / NO
ASTHMA	YES / NO
BLOOD DISORDERS	YES / NO
EPILEPSY	YES / NO
DIABETES	YES / NO
HEPATITIS	YES / NO
OTHER ILLNESSES	YES / NO
ADVERSE DRUG REACTIONS	YES / NO
MEDICATIONS – List Below	YES / NO

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HIGH RISK GROUP	YES / NO
ALLERGIES IE LATEX ALLERGY	YES / NO
ARE YOU INVOLVED IN ANY HIGH RISK ACTIVITIES	YES / NO

ANY OTHER HEALTH PROBLEMS:

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It is essential that full medical history is provided to enable proper care of the patient thus ensuring the best orthodontic treatment possible.

SIGNATURE- PATIENT/PARENT/GUARDIAN

……

NAME……

DATE……