straightsmiles
SPECIALIST ORTHODONTIC CARE

# Personal Information:

Miss / Mrs / Mr / Mstr

First Name _____ Surname _____

Preferred Name _____ Gender Male / Female

Date of Birth _____ Occupation _____ _____

Home Address _____ Phone (H) _____

_____ Phone (M)_____

Postcode _____ Hobbies/Interests _____

Email Address_____

## Account Information (Parent/Guardian)

Is the patient responsible for the account? Y / N If **NO**, please continue with this section:

Title: Miss / Mrs / Mr / Mstr Gender M / F Relationship to Patient _____

First Name _____ Surname _____

Home Address _____ Phone (H) _____

_____ Phone (M) _____

Postcode _____ Email _____

***Are there other Responsible Parties (e.g. other family members to receive correspondence and accounts)? Please list their details on the back of this form.

## Referral/Health Insurance Information

Do you have private health insurance? Y / N Fund Name _____

Is this your first visit to an orthodontic practice? Y / N

Do you have siblings or family members who also attend this practice (please list names)?

_____

## How did you first hear about our practice? Please tick.

Referred by doctor? Please name: _____

Referred by patient? Please name: _____

Google search ☐ Bus Advertisement ☐ Radio ☐ Invisible Orthodontist Website ☐

Saw practice ☐ Yellow Pages ☐ Facebook ☐ Invisalign Website ☐

Newspaper ☐ Cardinia Kids ☐ Shopping centre stall ☐

School Newspaper- Please Specify ☐_____

**PLEASE TURN OVER**

**General Dentist Information**. Dr: _____ Phone Number _____

Address: _____

**Who is your GP Information.** Dr: _____ Phone Number _____

Address: _____

**Are you on Facebook? Y / N Check out our page!!**

**Health Information**

| Do you suffer from: | Y | N |
|---|---|---|
| ➢ Heart/Vascular Disorder | ☐ | ☐ |
| ➢ Blood Disease/Bleeder | ☐ | ☐ |
| ➢ Blood Pressure Problem | ☐ | ☐ |
| ➢ Rheumatic Fever | ☐ | ☐ |
| ➢ Arthritis | ☐ | ☐ |
| ➢ Diabetes | ☐ | ☐ |
| ➢ Liver or Kidney Disease | ☐ | ☐ |
| ➢ Asthma | ☐ | ☐ |
| ➢ Epilepsy | ☐ | ☐ |
| ➢ Cold Sores | ☐ | ☐ |
| ➢ Hepatitis or HIV | ☐ | ☐ |
| ➢ Allergy/Hypersensitivity to Latex | ☐ | ☐ |
| ➢ Allergy/Hypersensitivity to other: _____ | ☐ | ☐ |
| ➢ If female; are you Pregnant? | ☐ | ☐ |
| ➢ Do you require antibiotic cover for dental procedures? | ☐ | ☐ |
| ➢ I consent to having my x-rays, models and photographs published for continuing dental education purposes. | ☐ | ☐ |
| ➢ I consent to The Dental Specialists using my images in social media networks and newsletter. | ☐ | ☐ |
| ➢ Other (please give details) | ☐ | ☐ |

_____

_____

**Signature** _____**Relation to Patient** _____ **Date**_____

*****Details of other Responsible Parties (if applicable):**

_____

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