Welcome To Our Office

Personal Information:

Title _____

First Name _____ Surname _____

Preferred Name _____ Male/Female _____

Date of Birth _____ Age _____ Occupation/School _____

Are you Aboriginal/Torres Strait Islander? Y/N

Is English your second language? If so, what other language do you speak?_____

Home Address _____ Phone (H) _____

_____ Phone (W)_____

Hobbies/Interests _____ Phone (M) _____

Email Address _____

Emergency contact details:

Title _____

First Name _____ Surname _____

Phone (H) _____ Phone (M) _____

Account Information (Parent/Guardian)

Is the patient responsible for the account? Y/N

If **NO**, please continue with this section:

Title _____ Relationship to Patient _____

First Name _____ Surname _____

Preferred Name _____ Male/Female _____

Home Address _____ Phone (H) _____

_____ Phone (M) _____

Email Address _____ Phone (W) _____

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? _____

Who is your dentist? _____ Who is your GP? _____

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

PTO ⟶

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	☐	☐
➢ Is there a possibility that you could be pregnant?	☐	☐
➢ Do you require antibiotic cover for dental procedures?	☐	☐
➢ Other (please give details)	☐	☐

_____

_____

Current medications(please give details) ☐ ☐

_____

_____

	Y	N
➢ I consent to having my x-rays, models and photographs published for continuing dental education purposes.	☐	☐
➢ I consent to Straight Smile Centre using my images in social media networks and practice newsletter.	☐	☐
➢ I consent to Straight Smile Centre using my email to communicate with me from time to time, about practice events, special offers and practice newsletters.	☐	☐

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