Dr Russell Lovatt
BDS (Otago), MDSc. (Western Australia)

Dr Christine Bailey
BDS (Otago), DCD (Melb), MOrtho RCS (Ed), MRACDS

PATIENT QUESTIONNAIRE
Please complete all details

Please return to us **prior to the appointment** in the envelope provided.

It is essential to have a full and accurate medical history recorded into the patients' electronic file prior to their appointment.

Appointment Details:		Ortho No:									

Family Name:		First Name:			
Preferred Name:		DOB:	/ /		
Address:		Home Ph:		Patient Mobile:	
		Work Mother:		Work Father:	
		Mobile: Mother		Mobile Father:	

If you would like text reminders, Please advise the mobile number to send these to:

Email Address:		Is this routinely monitored?	Yes ❑ No ❑
Patients school:		Or Patients occupation:	
Name of Dentist/ School Dentist Therapist:	Approx date of last dental check up:	Name of family Doctor:	
Other family members who see us:		Who referred you?	
How did you hear of us? (circle)	Family/friends Dentist/School therapist Our website Google./internet Yellow pages Advert Other_____		

Full name(s) and address of person(s) responsible for account and pre-treatment fees:

Surname:		First Name:		Title:	
Surname:		First Name:		Title:	
Address:		Relationship to Patient:			
		Phone No:			
		ACC No if applicable:			

If You Are An Overseas Student:

Name of Guardian:		Phone:	
Name and Address of Parents:			
		Phone:	

PLEASE TURN FORM OVER FOR HEALTH QUESTIONNAIRE ➔

All of this information remains strictly confidential

PatientsName:					
1.	Are you receiving any medical treatment at the present time?			Yes ❑ No ❑	
2.	Have you ever been in hospital for surgery/serious illness?			Yes ❑ No ❑	
3.	Have you ever had any of the following?			Yes ❑ No ❑	
Rheumatic Fever ❑		Epilepsy ❑		Drug Dependence ❑	
Heart Trouble ❑		Anaemia ❑		Depressive Illness ❑	
High Blood Pressure ❑		Diabetes ❑		Cold Sores ❑	
Asthma ❑		Severe Headaches ❑		Gastric Trouble ❑	
Arthritis ❑		Bronchitis or Chest ❑		Kidney Trouble ❑	
Hepatitis – Specify A, B, C ❑					
4.	Are you taking any tablets, capsules, medicines or drugs of any sort?			Yes ❑ No ❑	
If yes please list:					
5.	Have you had any allergies to medicines that you are aware of?			Yes ❑ No ❑	
If yes please list:					
6.	Are you wearing an artificial or prosthetic joint?			Yes ❑ No ❑	
7.	Have you ever experienced excessive bleeding or bruising?			Yes ❑ No ❑	
8.	Have you had any accidents to your head, face or teeth?			Yes ❑ No ❑	
9.	Have you ever come in contact with HIV or Hepatitis B virus?			Yes ❑ No ❑	
10.	Have you ever had a reaction to an anaesthetic?			Yes ❑ No ❑	
11.	Do you have any back or neck problems?			Yes ❑ No ❑	
12.	Do you have a heart murmur that requires antibiotic cover for dental extractions			Yes ❑ No ❑	
13.	Female, Are you currently pregnant?	Yes ❑ No ❑		If yes, how many months:	
Are there any other aspects concerning your health that you think your Orthodontist should know about?					
Do you consent to the use of your treatment records for educational or communication purposes?				Yes❑ No ❑	

Agreement to pay for the consultation fee:

I undertake to pay/or be responsible for ensuring the orthodontic consultation fee is paid at the time of the consultation appointment.

If it is the intention that the consultation fee is to be covered by a third party, eg. ACC, Medical Insurance **I understand that I am liable for the full cost of the consultation fee at the time of the appointment** and will be reimbursed by the practice if the practice is paid by the third party at a later date.

In the event of non-payment of the account, I will be liable for any recovery costs that may be incurred in obtaining payment of the account.

I also understand and give consent for some treatment to be provided by registered Orthodontic Auxiliaries, or at times orthodontic auxiliaries in training for registration. I understand that all treatment will be under the direction of the orthodontist and that I have the right to ask that only registered oral health practitioners carry out this treatment.

I/we confirm that the information contained is true and correct to the best of my/our knowledge:

Signed: Patient / Parent / Guardian (Please circle)		Date:	
Please print your name:			
Comments or additional information:			
Medical History updated on:			