WYNDHAM ORTHODONTICS

New Patient Registration Form

Patients Details

Title | First name | Surname

Preferred name | Date of birth

Address

Suburb | Postcode

Home phone | Work phone

Mobile | Email address

Occupation

Emergency Contact Details

Name | Contact number | Relationship to patient

Medical History (Please tick any which are applicable)

- ☐ Asthma
- ☐ Anxiety
- ☐ Heart Condition
- ☐ Rheumatic Fever
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Lung Condition
- ☐ Speech/Hearing Problem
- ☐ ADHD
- ☐ Sleep Apnoea
- ☐ Bone Disorder
- ☐ Bleeding Disorder
- ☐ Infectious Disease
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Tonsils Removal

Any other relevant medical history

Any previous **surgery**

Do you smoke? ☐ Yes ☐ No | If yes, how many per day?

Are you pregnant or hoping to be? ☐ Yes ☐ No | If yes, how many weeks?

Allergies

Do you have any allergies ☐ Yes ☐ No | Details of allergy

Emergency plan

Medications (Please list any medications that you are **currently taking** or have taken recently)

Dental/Orthodontic History

Do you have any of the following habits?

Mouth breathing ☐ Yes ☐ No

Thumb/Digit Sucking ☐ Yes ☐ No

Teeth Grinding/Clenching ☐ Yes ☐ No

Have you had any previous orthodontic opinion?

☐ Yes ☐ No

Have you had any previous orthodontic treatment?

☐ Yes ☐ No

Any history of trauma or injuries to the teeth or jaws? ☐ Yes ☐ No

If yes, details

What is the **main concern** about your teeth and what is purpose of the visit?

Who is concerned about your teeth/child's teeth? ☐ You ☐ Your child ☐ Dentist ☐ Other: _____

Dentist Details

Name of practitioner

Date of last check up

Clinic name and address

Suburb

Postcode

Are you happy for us to email your report?

Dentist ☐ Yes ☐ No

Other Specialists ☐ Yes ☐ No

Who recommended our practice to you?

☐ Dentist ☐ Internet

☐ Friends/Family ☐ Other: _____

Private Health Insurance

Do you have private health insurance? ☐ Yes ☐ No

If yes, do you have: ☐ Dental ☐ Hospital

Name of Health Fund

Person Responsible For Fees

Name

Contact number

Address

Suburb

Postcode

Email address

Relationship to patient

☐ I agree to be responsible for all payment of fees and understand that payment is due at the time of service

Signature

Date

Privacy Policy- We collect information in order to provide you with dental services. We will keep your information confidential and secure. We may require to pass on your information to other health practitioners when necessary for referral purposes. We may also be required by law to provide your information to outside agencies.