Lupton Stewart ORTHODONTICS

www.luptonstewart.com.au

Medical and Dental History

Information provided by you is considered 'Confidential' and is not released to any party without your prior consent

Patient's **FIRST NAME**

Patient's **SURNAME**

Date of Birth

Preferred Name

☐ Male ☐ Female

School (if applicable)

Briefly describe what concerns you most about your/ your child's teeth

Dentist who normally treats patient: ☐ School dentist ☐ Private dentist ⇨ Name:

How did you find out about the practice: ☐ Referral ☐ Family ☐ Friend ☐ YellowPages ☐ Internet ☐ Signage

Family members who have previously visited our practice (incl surname if different to above)

Mother/ Guardian's Name (for patients younger than 18 yrs)

Father/ Guardian's Name (for patients younger than 18 yrs)

Residential address
(Other than a PO Box)

Postal address
(Complete ONLY if other than residential above)

Contacts:

Phone (Mob)

Email:

Phone (H)

Phone (W)

Name of Account Holder

Relationship: ☐ Mother ☐ Father ☐ ________________

Contact phone

Account address

Is patient transferring from another Orthodontist ? Name & city:

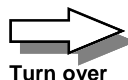
For patients not transferring, has any previous orthodontic treatment been undertaken ?

☐ Removable plates ☐ Fixed braces ☐ Tooth extractions ⇨ When ?

Is the patient covered by Private Health Insurance ?
(*This information has no relevance to the treatment provided or its cost—it is used only in the event your insurer contacts us direct)*

☐ BUPA (MBF) ☐ Medibank Private ☐ Teacher's Health ☐ Westfund ☐ NIB ☐ AHM ☐ HCF

☐ Employer sponsored ☐ Other ⇨



Turn over

I have confidential information that I don't wish to write down — I would prefer to discuss this with the Orthodontist (tick) ☐

Please provide the following information for the person (you or your child) to be examined by the Orthodontist

	NO	YES	Provide details if you ticked YES
Are any tablets, pills or medicines (including over-the counter and prescribed) being taken ?	☐	☐	
Is the patient being treated by a medical practitioner for any condition at present ?	☐	☐	
Are antibiotics required BEFORE any dental treatment ?	☐	☐	
Do you know if any allergies (including drug, nickel and latex) exist ?	☐	☐	
FOR FEMALES ONLY… are you pregnant or suspect you may be pregnant ?	☐	☐	
Has there been any serious injuries involving the head, face, mouth or teeth ?	☐	☐	
Is there any family history of adult/ permanent teeth not developing ?	☐	☐	
Has there been any history of prolonged jaw joint (TMJ) pain, discomfort or clicking/ noises ?	☐	☐	

Please tick appropriate box if the patient has, or ever had, any of these medical conditions — then provide details below

	NO	YES		NO	YES		NO	YES
Heart disorder	☐	☐	Organ transplant	☐	☐	Prosthetic implant incl. Shunt, limb etc	☐	☐
Asthma	☐	☐	Thyroid disorders	☐	☐	Heart valve disorder incl. Heart murmur	☐	☐
Epilepsy	☐	☐	Excessive bleeding	☐	☐	Hepatitis or other liver disease	☐	☐
Diabetes	☐	☐	Tuberculosis	☐	☐	Exposure with AIDS/ HIV	☐	☐
Kidney disease	☐	☐	Radiation therapy	☐	☐	Other blood disorders	☐	☐
Rheumatic fever	☐	☐	Nervous condition	☐	☐	Drug dependency (current or past)	☐	☐

Medical details where 'YES' ticked — include approximate year of condition diagnosis, its treatment and other relevant information

Medical practitioner & address — only provide where significant medical condition exists

Declaration and Consent relating to medical/ dental information and examination

- I authorise the orthodontist to complete a preliminary examination of myself/ my child and by doing so become responsible for the fee charged to complete this procedure—this fee must be paid on the day of examination. Where I fail to commit to paying this account or discuss an alternative arrangement I understand my personal details may be forwarded to a debt recovery agency and I will be responsible for related costs
- I declare that the information provided in this medical/ dental history is accurate at this time and I have disclosed all relevant medical and dental history
- I consent to other health practitioners or related parties being consulted where it will assist in the provision of appropriate orthodontic advice and treatment
- I consent to this contact with other practitioners or parties being verbal, written and electronic (by email or fax)
- I understand that I should advise the orthodontist if this medical/ dental history changes during the course of treatment
- I understand this medical/ dental history and my/ my child's orthodontic treatment information is 'Confidential' and not made available to any other party unless governed by State or Federal laws or where authorised by me

Signature of parent, guardian or patient of 18 yrs or more

Date

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Phone: (07) 4921 0399

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