TORQUE
orthodontics

Please complete your CHILD'S PERSONAL & MEDICAL HISTORY

Patient's full name:.....Preferred name: .....

Date of birth:.....Gender: Female / Male

Mobile No #1:.....Mobile No # 2:.....

Address.....

Postal: .....Home No: .....

Email Parent/Guardian: .....

Father's full name: .....Occupation: .....

Mother's full name: .....Occupation: .....

Financially Responsible- Name & Address: .....

Email for statements: .....

Siblings: .....

Name of Health Fund .....

General Dentist: ..... Family Physician: .....

Date of last Dental check-up: .....

- Reason for seeking orthodontic treatment:.....

  .....

- Do you feel there is need for orthodontic treatment? YES NO
  If "YES" please provide details

  .....

- Has the patient had an orthodontic consultation previously? YES NO
  If "YES" please provide details

  .....

- Has the patient had any previous orthodontic treatment? YES NO
  If "YES" please provide details

  .....

- Has the patient had any injuries to the teeth (both baby & permanent), face, jaws or chin?
  YES NO
  If "YES" please provide details

  .....

- Has the patient had any cysts or tumors of the jaws or gums? YES NO
  If "YES" please provide details

  .....

- Has the patient been informed of any missing or extra permanent teeth? YES NO
  If "YES" please provide details

  .....

- Has either parent had orthodontic treatment? YES NO
  If "YES" please provide details

  .....

- Is the patient in good health? YES NO
  If "NO" please provide details

  .....

- Have you ever had any serious medical or surgical problems? YES NO
  If "YES" please provide details

  .....

- Is the patient under any physicians care for any problems at this time? YES NO
  If "YES" please provide details

  .....

- Does the patient have any allergies? (eg Latex, Medicines, Foods or Drug Sensitive etc.) YES NO
  If "YES" please provide details

  .....

- Is the patient taking any medication? YES NO
  If "YES" please provide details

  .....

- Is the patient suffering from (or have you ever had) any of the following? (Please tick)

  ☐Rheumatic fever ☐Heart disease/Heart Murmur ☐High/Low blood pressure

  ☐Stroke ☐Rheumatism ☐Asthma- Mild, Moderate, Severe

  ☐Diabetes ☐Fits/ Epilepsy/Fainting/Dizziness ☐HIV/AIDS

  ☐Hepatitis ☐Any blood disorder ☐Joint problems/replacement

  ☐Disorder of the stomach, bowel or digestive system ☐Cancer/Tumors (Benign/ Malignant)

  ☐Osteoporosis

  .....

- Does the patient have any medical conditions that requires ANTIBIOTIC COVER for dental treatment?
  YES NO

  .....

- Are there any other medical or physical conditions we need to know about YES NO
  (e.g. Learning difficulties, Anxiety, Hearing impairment, Autism Spectrum Disorder, Speech, Bed wetting etc.)

  .....

- Has the patient reached puberty? YES NO

  Girls (Has menstruation started) Age menstruation commenced .....
- Boys (Has there been a change in voice?) YES NO

Please note that we only treat you according to the information you have provided for us.

If there is any information that you would not like discussed but is relevant to your dental history, please detail.

.....

We are most appreciative if you take the time to let us know how you heard about our office.

.....

Why you chose treatment with the team at Torque Orthodontics.

.....

Name:.....

Signature: ..... Date: ..... / ..... / .....
(Parent or guardian if child is less than 18 years of age)

PRIVACY CONSENT

The Privacy Act of December 21, 2001 states that we must have consent to collect personal information about you. Please read this information carefully and sign, where indicated, below.

This dental practice collects information from you for the primary purpose of providing quality dental care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your dental care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our dental Practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your dental care, including treating doctors, specialists, and other para medical personnel including educators, community health and hospital staff, outside this dental practice. This may occur through referral to other doctors, or for medical tests including imaging / radiology and in the reports returned to us following the referrals.
- Disclosure to other orthodontists in the practice, locums and by Registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records assessed for these purposes, and we will note your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of. This consent is valid indefinitely.

Signature: ..... Date: ..... / ..... / .....
(Parent or guardian if child is less than 18 years of age)