Personal Details:

Title:____________ Full Name:________________________________ Preferred Name:______________

DOB:____/____/____ Address:____

Mobile Phone:_____________________________________ Home Phone:_________________________

Email Address:____________________________________ Occupation:__________________________

Whom may we thank for referring you?

☐ Google ☐ Facebook ☐ Signage ☐ TV Ad ☐ WOM

Please rate your dental phobia on a scale. None 1 2 3 4 5 6 7 8 9 10 High

Would you like to receive our latest news via Email? Yes / No

Would it be okay if we contact you regarding your future appointment via SMS? Yes / No

Would you allow photos to be taken for diagnostic purposes and records keeping? Yes / No

Emergency Contact and Medical History:

Emergency Contact: ___________________________________ Phone:______________________________

Are you in a health fund? If so, which one? ____

Doctor Practice Name: ____________________________ Doctor's Phone:_________________________

Do you weigh more than 140 kg? Yes / No (For treatment safety only). _____________kg

Please tick if you have or had any of the following:

Heart Murmur	YES / NO	High Blood Pressure	YES / NO
Heart Surgery	YES / NO	Rheumatic fever	YES / NO
Diabetes	YES / NO	Asthma	YES / NO
Epilepsy / Seizures	YES / NO	Fainting /Dizzy Spells	YES / NO
Hepatitis A, B or C	YES / NO	HIV/ AIDS	YES / NO
Prolonged Bleeding	YES / NO	Bruise Easily	YES / NO
Kidney Trouble	YES / NO	Radiation/Chemo	YES / NO
Depression	YES / NO	Anxiety	YES / NO
Osteoporosis	YES / NO	Thyroid Problem	YES / NO
Liver Disease	YES / NO		

Please list any medication that you are allergic to.

____

Please list any medication you are taking at the moment, including any over the counter medication.

____

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In our practice, we are very interested in our patients' overall health. Orthodontic treatment can be an important part of managing health problems caused by sleep and breathing disorders.

Paediatric Sleep and Orthodontic Questionnaire:

Does your child have frequent headaches or migraines?	YES / NO
Has your child ever suffered a severe blow to the head?	YES / NO
Does your child have jaw pain?	YES / NO
Does your child hear clicking or popping from the jaw joint?	YES / NO
Does your child have difficulty opening their mouth wide?	YES / NO
Does your child's jaw ever get locked?	YES / NO
Does your child suffer from ringing in the ears?	YES / NO
Does your child tend to breathe through the mouth during the day?	YES / NO
Does your child snore, or breathe loudly in sleep?	YES / NO
Does your child occasionally wet the bed, sleep walk, or have night terrors?	YES / NO
Is it hard to wake up your child in the morning?	YES / NO
Does your child wake up with dry mouth in the morning?	YES / NO
Does your child wake up unrefreshed in the morning?	YES / NO
Has a teacher or supervisor commented that your child appears sleepy during the day?	YES / NO
Is your child doing well at school?	YES / NO
Did your child stop growing at a normal rate at any time since birth?	YES / NO
Is your child easily distracted by extraneous stimuli?	YES / NO
Does your child seem always 'on the go' as if 'driven by a motor'?	YES / NO
Has your child been diagnosed with ADD/ADHD?	YES / NO

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in completion of this form. I understand that it is my responsibility to inform the doctor if I, or my minor child, ever have a change in health.

Parent / Guardian: (Print Name) ______________________________

Signature:______________________________ Date:______________________

Thank you for your time filling out this medical questionnaire.