



# NEW ORTHODONTIC PATIENT QUESTIONNAIRE

Flip Long

Welcome to Dr. Wexler's Orthodontic practice

DATE this form filled in ...../...../.....

Please fill in both sides of this form.

Please give it to our Receptionist on arrival

PATIENT Miss / Ms / Mrs / Mr / Dr / Prof / Master Surname ..... Date of Birth ..... / ..... / ..... Age .....

Given Names ..... Preferred Name .....

Street Address ..... Suburb ..... Post Code ..... Telephones (Mobile) .....

(H) ..... (W) ..... E-MAIL ..... Occupation .....

Whose idea was it for patient to seek orthodontic treatment: (circle) Self Parent Dentist Other Person.....

DENTIST'S NAME ..... Last Seen ..... Reason.....

Primary way this practice was selected: (circle) Dentist Family Website Friend Our Staff Sign Our Patient..... Other.....

Other reason this practice was selected: (circle) Dentist Family Website Friend Our Staff Sign Our Patient..... Other.....

For Patients under 18 Years of Age .....

SCHOOL & CAMPUS .....

Father's Occupation ..... Ph ..... Mob .....

Mother's Occupation ..... Ph ..... Mob .....

### Person paying account:

Surname ..... Given Names ..... Ph ..... Mob .....

Address .....

### Partner of person paying account

Surname ..... Given Names ..... Ph ..... Mob .....

Address .....

Health Fund Name ..... Dental Extras Cover: Yes / No ..... Hospital Cover: Yes / No

The information requested below is vital to orthodontic assessment and will be kept confidential

Circle YES / NO / DKU & DESCRIPTIVE WORDS for the conditions, events or possibilities DKU = Don't Know or Understand

## PATIENT PROFILE

- Yes / DK/U / No Does patient follow directions well?
- Yes / DK/U / No Does patient brush teeth conscientiously?
- No / DK/U / Yes Does patient have learning disabilities or need extra help with instructions?
- No / DK/U / Yes Is the patient self-conscious about teeth?
- No / DK/U / Yes Does the patient *smoke*? Number per day?.....
- Yes / DK/U / No Does the patient eat a well balanced diet?

## MEDICAL INFORMATION

State all known medical conditions affecting patient:-.....

### MEDICAL DOCTORS Names, Suburb & Phone Number

..... Date of last exam.....

### IN THE PAST OR PRESENT HAS PATIENT HAD:-

- No / DK/U / Yes Hospitalization For what? .....
- No / DK/U / Yes Operations? For what? .....
- No / DK/U / Yes Allergies (e.g. Penicillin, Aspirin, Ibuprofen, Latex, Vinyl, Acrylic, Nickel, Foods, Animals, Sinus Trouble, Hives, Other .....
- No / DK/U / Yes Breathing, ear nose or throat problems (e.g. adenoids, sinuses)
- No / DK/U / Yes Risks for Tuberculosis AIDS, Hepatitis, HIV, Other
- No / DK/U / Yes Polio, Pneumonia, Mononucleosis
- No / DK/U / Yes Birth Defects or hereditary problems
- No / DK/U / Yes Bone fractures of major accidents
- No / DK/U / Yes Rheumatoid or arthritic problems
- No / DK/U / Yes Kidney problems
- No / DK/U / Yes Diabetes
- No / DK/U / Yes Cancer, tumour, radiation or chemotherapy

- No / DK/U / Yes Stomach ulcer or hyper-acidity
- No / DK/U / Yes hepatitis, jaundice, hepatitis, liver problems
- No / DK/U / Yes Fainting, seizures, epilepsy, neurological problems
- No / DK/U / Yes Mental health disturbance or depression
- No / DK/U / Yes Vision, hearing, tasting or speech problems
- No / DK/U / Yes Weight loss or poor appetite
- No / DK/U / Yes Eating disorder, anorexia bullemia
- No / DK/U / Yes Bleeding or bruising easily or anaemia
- No / DK/U / Yes Blood pressure high or low
- No / DK/U / Yes Tired Easily
- No / DK/U / Yes Chest pain, shortness of breath, ankle swelling
- No / DK/U / Yes Cardio-vascular problem, heart attack, stroke, angina, valve defects or murmurs, rheumatic heart disease, other .....
- No / DK/U / Yes Skin disorders
- No / DK/U / Yes Frequent headaches, colds
- No / DK/U / Yes Are antibiotics needed before dental treatment

### IS PATIENT TAKING MEDICINE, NUTRIENT SUPPLEMENT, HERBAL MEDICINE?

- TAKING ..... FOR .....
- TAKING ..... FOR .....
- TAKING ..... FOR .....
- TAKING ..... FOR .....

### WOMEN ONLY

No / DK/U / Yes Is the patient pregnant or planning to become pregnant

PLEASE TURN OVER

**DENTAL ARE THER OR HAVE THERE BEEN**

- No / DK/U / Yes Chipped, knocked or injured teeth
- No / DK/U / Yes Teeth overly sensitive to cold or hot
- No / DK/U / Yes Cysts or jaw fractures
- No / DK/U / Yes "Dead" or dark teeth or root canal treatments
- No / DK/U / Yes Bleeding gums bad taste or mouth odour
- No / DK/U / Yes Gum Problems or disease
- No / DK/U / Yes Food impaction between teeth
- No / DK/U / Yes Loose or broken fillings
- No / DK/U / Yes Teeth irritating cheeks or tongue
- No / DK/U / Yes Gum boils or lumps in mouth
- No / DK/U / Yes Trouble with previous dental treatment

**PLEASE MENTION ALL UNRESOLVED DENTAL PROBLEMS**

**JAW JOINTS HAS THE PATIENT HAD**

- No / DK/U / Yes Tooth grinding or clenching habit
- No / DK/U / Yes Jaw joint pains or ringing in the ears
- No / DK/U / Yes Aches in the face or muscles around the ears
- No / DK/U / Yes Difficulty chewing or opening jaw
- No / DK/U / Yes Injury to jaws (car / sport / knock)
- No / DK/U / Yes Mouth Breathing Snoring

**DENTAL TIMING, NUMBER & HABITS**

**HAS THE PATIENT HAD**

- No / DK/U / Yes Late arrival of teeth
- No / DK/U / Yes Removal of baby teeth that were not loose
- No / DK/U / Yes Congenitally missing teeth
- No / DK/U / Yes Extra or "Supernumerary" teeth
- No / DK/U / Yes Thumb or finger sucking habit

No / DK/U / Yes Abnormal swallowing or tongue thrust

No / DK/U / Yes Speech difficulties or therapy

**SMILE QUESTIONS - ARE THE PATIENT'S TEETH**

- No / DK/U / Yes Too protrusive (stick out, buck)?
- No / DK/U / Yes Too large or long?
- No / DK/U / Yes Too pointy?
- No / DK/U / Yes Too retrusive-hard to see (too far back in mouth)?
- No / DK/U / Yes Too small or short?
- No / DK/U / Yes Too worn or mis-shapen
- No / DK/U / Yes Off colour?

**OTHER CONCERNS IS THERE CONCERN ABOUT**

- No / DK/U / Yes Shyness or dislike of smiling?
- No / DK/U / Yes Teasing at school?
- No / DK/U / Yes Spaces between teeth
- No / DK/U / Yes Crooked teeth?
- No / DK/U / Yes Showing too much gum?
- No / DK/U / Yes Under-sized jaw?
- No / DK/U / Yes Over sized jaw? \
- No / DK/U / Yes Chin or Nose Shape or Position? How?
- No / DK/U / Yes Would patient object to wearing normal braces?
- No / DK/U / Yes Are concealed or invisible braces desired?
- No / DK/U / Yes Has there been any past orthodontic treatment? With whom & when?.....
- No / DK/U / Yes Has there ever been another orthodontic opinion? With whom & when?.....

What are the main concerns about the arrangement of the teeth?

**I understood the questions on this form and I will not hold the doctor or practice responsible for errors & omissions. I will inform**

**the practice of changes. Signed..... Patient/ Parent / Guardian Name..... DATE.....**

**Tick if you \*don't\* wish to receive appointment reminders by:  SMS  e-mail**

**YOUR HEALTH INFORMATION AND OUR PRIVACY POLICY**

In accordance with the Victorian Health Records Act 2001 and Privacy Act

Our practice respects your right to privacy. We realise that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice and to whom this information might be disclosed.

The policy of our practice is to follow these procedures:

1. The information collected will be used for the purpose of providing treatment to you. Personal information such as your name, address and health insurance details will be used for the purpose of addressing accounts to you, as well as processing payments and writing to you about our services and any issues affecting your treatment.
2. We may disclose your health information to other health care professionals, or require it from them if, in our judgment, that is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimized wherever possible.
3. We may use images or parts of your health information for research and educational purposes, in study groups or at patient presentations as examples of orthodontic issues and treatments that are possible, to provide benefit to other patients. You may see other patient images in this process, for your benefit. Identity will remain undisclosed.

4. Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time, or seek an explanation from the orthodontist. Statutory fees will apply in relation to the types of access you seek. If you request an explanation of our records or a written summary, our usual fees apply to these services.

5. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

You can otherwise rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice without your prior written consent. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

Please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of your health information in this way.

**Signed:..... Patient/ Parent / Guardian Name:-**

**..... Date .....**

**Usual consultation costs: \$130 per Child; \$160 per Adult.----- Extended consultations & unusual reports will attract surcharges.**