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**....................................

Emergency contact details;

Full Name.................................... Relationship.................................... Contact number....................................

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 MEDCINE, NUTRIENT SUPPLEMENT, HERBAL MEDICINE?

TAKING .... **FOR** ....

TAKING .... **FOR** ....

TAKING .... FOR

....

TAKING .... FOR

....

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

WOMEN ONLY

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

PLEASE TURN OVER

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 CONCENRN 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

OUR HEALTH INFORMATION AND OUR PRIVACY POLICY (APRIL 2017)

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. Permission is granted that we may disclose your health information, including by e-mail, to other healthcare professionals or require it from them if, in our judgment, that is necessary in the context of your treatment. We may e-mail such information to you. Such transmissions may be seen or read inadvertently by persons other than the consulting practitioner or people intended to see it. Disclosure of your personal details will be minimized wherever possible.

3. Permission is granted use images or parts of your health information for research and educational purposes, in study groups or at patient or scientific presentations as examples of orthodontic issues and treatments that are possible, to provide benefit to other patients. You yourself may benefit by seeing other patient's de-identified images during this process.

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 may 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: $170 per Child; $200 per Adult.

Extended consultations & unusual reports will attract surcharges.