PATIENT INFORMATION

Junction ORTHODONTICS

PATIENT DETAILS

Full Name:..... Preferred Name:.....

Address:..... Postcode:.....

Telephone: Home:..... Mobile:.....

Email:.....

Date of Birth:..... Sex: ☐ Male ☐ Female

If patient is under 18, please complete the following

Parent / Guardian 1

Name:..... Relationship:.....

Address: ☐ AS ABOVE or..... Postcode:.....

Telephone: Mobile:..... Home:.....

Email:.....

Parent / Guardian 2

Name:..... Relationship:.....

Address: ☐ AS ABOVE or..... Postcode:.....

Telephone: Mobile:..... Home:.....

Email:.....

Who is responsible for the account: ☐ Parent/Guardian 1 ☐ Parent/Guardian 2 ☐ Self ☐ Other:.....

Name of Health Fund: ☐ NOT APPLICABLE or.....

We use the following methods of contact (unless you advise us otherwise):

Appointment Reminders: via SMS Preferred Mobile:.....

Recall Reminders: via Email Preferred Email:.....

Receipts and Statements: via Email Preferred Email:.....

MEDICAL HISTORY

Dentist's Name:.....

Medical Practitioner's Name:.....

Are you under regular care with your medical practitioner? ☐ Yes ☐ No

If yes, please provide reasons:.....

Have you taken any regular medication in the past year? ☐ Yes ☐ No

If yes, please provide details:.....

Is there any reason for you to suspect that you are at risk of having any blood borne viral disease? ☐ Yes ☐ No

Have you ever suffered from any of the following:

Rheumatic fever?	☐ Yes ☐ No	Treatment for cancer?	☐ Yes ☐ No
Heart murmur?	☐ Yes ☐ No	Hypertension?	☐ Yes ☐ No
Haemophilia or prolonged bleeding after injury or surgery?	☐ Yes ☐ No	Ear, nose or throat surgery (ie. adenoids, tonsils, grommets)?	☐ Yes ☐ No
Any blood transfusion?	☐ Yes ☐ No	Hepatitis?	☐ Yes ☐ No
Diabetes?	☐ Yes ☐ No	Epilepsy?	☐ Yes ☐ No
A heart condition?	☐ Yes ☐ No	Any blood disorder?	☐ Yes ☐ No
Asthma?	☐ Yes ☐ No	Any other illness or disability?	☐ Yes ☐ No
Allergy to any food or drug?	☐ Yes ☐ No	(Females) Are you pregnant?	☐ Yes ☐ No

Signature:..... Date:.....

(Parent / Guardian if applicable)