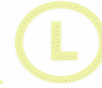


LAVRIN & LAWRENCE ORTHODONTICS

ADULT PATIENT INFORMATION & MEDICAL HISTORY FORM

Patient's Surname ______________________ First Name__________________ Middle Initial_____
Title: ❑ Mr ❑ Mrs ❑ Miss ❑ M/s ❑ Dr ❑ Other ________ Gender: ❑ Male ❑ Female
Date of Birth ___/___ / ___ Age: ______
Home Address ____Post Code___________
Telephone: Home__________________ Work__________________ Mobile_________________
E-mail____
Patient's Occupation ____
Work Address ____Post Code___________
Other family members in the practice____
Patient's Dentist & address ____
Patient's Doctor ____
Does the patient have Dental Insurance for Orthodontics? YES / NO Which Fund? ______________

Who can we thank for referring you?
❑ Dentist ❑ Family ❑ Friend ❑ Yellow pages book ❑ Advertisement __________________
❑ Internet – circle: Google / Our Website / Citysearch / Yellow Pages Online / Other ______________
❑ Other _______________________ Referrer's name_______________________________________

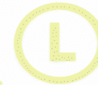
PARTY RESPONSIBLE FOR FEES: ❑ Self / ❑ Other – relationship to patient _____________________
Contact details **if not self**:
Name (include title) ____
Address ____
Home Phone ____________________________ Work Phone______________________________
Mobile__________________________________E-mail______________________________

PATIENT'S DENTAL HISTORY
Have any teeth been extracted? ____
Any missing permanent teeth? ____
History of trauma to teeth, mouth or face ____
Past or present habits (ie: thumb /finger sucking, tongue thrusting, lip biting, etc)________________
Past orthodontic consultation____
Past orthodontic treatment (eg: plates /braces)____
Other significant dental history (eg: missing teeth, root canal, TMJ) ___________________________
Main concerns about patient's teeth? ____

PATIENT'S MEDICAL HISTORY (Please tick where applicable)

❑ Asthma	❑ Birth defects	❑ Bleeding disorders	❑ Bone disorders
❑ Diabetes	❑ Emotional problems	❑ Epilepsy	❑ Growth problems
❑ Heart murmur	❑ Heart disease	❑ Hepatitis	❑ High blood pressure
❑ Headaches/Migraines	❑ HIV / AIDS	❑ Kidney disease	

❑ Allergies ____
❑ Other____
❑ Current Medication____
Should you have any medical condition, which may require further precaution or discussion, please advise ❑

LAVRIN & LAWRENCE ORTHODONTICS 

To the best of my knowledge, the above information is complete and correct.

Patient Signature__________________ Name _______________________ Date______________

PRIVACY POLICY

In accordance with the Victorian Health Records Act 2001 and Federal Privacy Act 1988, we consider the protection of your privacy and personal information to be a high priority. Therefore, we realise that it is important that you are aware of why we collect, how we use and to whom we may disclose your information.

The policy of our practice is to follow these procedures:

- The information collected will be used for the purposes of providing treatment to you. Personal information such as your name, address and other details will be used for the purpose of accounts and payments, and writing to you about your treatment and our services.
- We may disclose your health information to other health care professionals or require it from them if necessary for your treatment. In that event, disclosure of your personal details will be minimised.
- We may also use parts of your health information for research purposes in study groups or at seminars and lectures as this may provide benefit to other patients. Your personal identity will not be disclosed.
- If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

We respect your privacy and this information will be held in the strictest confidence.

Please sign here as confirmation that you understand and consent to our privacy policy.

Patient Signature__________________ Name ______________________ Date______________

AUTHORITY TO REQUEST/REFER RECORDS TO HEALTH CARE PROVIDERS

We may need to request records from your previous or current dentist or specialist to assist with your orthodontic treatment planning. We also correspond and forward x-rays when required, with your dentist or other specialists for treatment planning. During your treatment, we may need to refer you to other specialists. To ensure compliance with Federal and State Privacy Legislation we require your signed consent to work with other health care professionals.

Patient Signature__________________ Name ______________________ Date______________