LAVRIN & LAWRENCE ORTHODONTICS

CHILD PATIENT INFORMATION & MEDICAL HISTORY FORM

Patient's Surname _____ First Name_____ Middle Initial_____
Title: ❑ Miss ❑ Master Gender: ❑ Male ❑ Female
Date of Birth ___/___ / ___ Age: _____
Home Address _____Post Code_____
Telephone: Home_____ Work_____ Mobile_____
E-mail_____
Patient's School or Occupation _____
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_____

PARENT DETAILS

Father: Name (include title) _____
Address as above/other_____
Home Phone as above/other_____ Work Phone_____
Mobile_____E-mail_____
Do you want **correspondence** and/or **accounts** sent? (if yes, please circle one or both)
Mother: Name (include title)_____
Address as above/other_____
Home Phone as above/other _____ Work Phone _____
Mobile_____ E-mail_____
Do you want **correspondence** and/or **accounts** sent? (if yes, please circle one or both)

PARTY RESPONSIBLE FOR FEES: Father / Mother / Other – relationship to patient _____

Contact details **if not parent**:
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? _____

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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, please advise ❑

If you wish to discuss any medical aspects in private (ie: without the patient), please tick box: ❑

Has the patient reached puberty? Girls- Has menstruation started? ❑Yes ❑ No

Boys- Has voice changed? ❑Yes ❑ No

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

Parent 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.

Parent 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.

Parent Signature_____ Name _____ Date_____