Smile Envy – Medical / Dental History Form

Please ensure you check all populated fields for any errors. To assist us in providing the best treatment we can for you / your child, please answer these questions as completely as possible. This information is strictly confidential.

Patient details:

Title: First Name: Surname:

Date of Birth: School / Occupation: Health Insurance Fund:

Address:

Suburb / Postcode: Email: **Note: we correspond via email**

Phone: home - work/mobile -

Dentist: Doctor:

Parent/Guardian(s) if under 18:

Title: Name: Relationship to above: Responsible for paying account: Y/N

Address: Phone:

Title: Name: Relationship to above: Responsible for paying account: Y/N

Address: Phone:

Where did you hear about us? Please circle — Internet | Clear Choice Orthodontist | School | Signage | Social Media | Dentist | Family / Friend

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Dental History:

What would you like changed about your teeth?

Straighten the front teeth – upper / lower:

Make the upper front teeth – longer / shorter:

Show more / less of my teeth when I smile:

Other:

Dental Questions

How often are your teeth brushed? Flossed?

When did you last visit your dentist?

Any past or present thumb, finger or any other sucking habits? Y / N

Any injury or discomfort to your face, jaws or teeth? Y / N

Do the gums bleed when brushed? Y / N

Any previous orthodontic treatment? Y / N

Are there any cavities and / or toothaches? Y / N

Any difficulty opening or closing the mouth? Y / N

Medical History – Any further information about a medical condition please explain adjacent or in the space below

Y / N	Allergies	Y / N	Anemia	Y / N	Arthritis
Y / N	Asthma	Y / N	Bleeding disorders	Y / N	Bone density problems
Y / N	Cancer or Tumour	Y / N	Cerebal Palsy	Y / N	Cleft Lip and/or Palate
Y / N	Diabetes	Y / N	Epilepsy	Y / N	Emotional/behavior problems
Y / N	Fainting or Dizziness	Y / N	Growth problems	Y / N	Hearing problems
Y / N	Heart disease or murmur	Y / N	Hepatitis	Y / N	HIV or AIDS
Y / N	Kidney problems	Y / N	Learning disabilities	Y / N	Pregnant
Y / N	Problems at birth	Y / N	Regular medication	Y / N	Tuberculosis
Y / N	Smoker	Y / N	Speech problems	Y / N	Tonsil/adenoid/sinus problems
Y / N	Sleep problems	Y / N	Snore/sleep apnea	Y / N	Wake feeling un-refreshed
Y / N	Sleepy during the day	Y / N	Aware if you stop breathing during sleep		

Please explain:

HOBBIES/INTERESTS:

Signed: **Date:** D / M / Y