SMILE ENVY

the smile you've always wished for...

Medical 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: ____________ Address: ____

Suburb / Postcode: ________________ Phone Number - Mobile: _____________________________

Alt (Work/Home): _______________________ Email: ____

Health Insurance Fund: ________________ Dentist & Practice: ____

Parent/Guardian if under 18:

Title: ______ Name (first and last): __________________________________ Relationship to above: ___________________

Phone: _________________________________ Responsible for paying account: Y/N

Address (if different from above): ____

Where did you hear about us? Please circle.	Clear Choice Orthodontist	Family / Staff	Google / Social Media	Signage	Dentist	Friend	School / Other

If other please explain: ____

Dental History:

How often are your teeth brushed? ________________ How often do you floss?_______________

Do the gums bleed when brushed? Y / N When did you last visit your dentist? ________________

Are there any cavities and / or toothaches? Y / N Have you had previous orthodontic treatment? Y / N

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 Any difficulty opening or closing the mouth? Y / Na

Please explain all Y circles: ____

Medical History: Please circle.

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	Tonsil/adenoid/sinus problems	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/Speech difficulties	Y / N	Pregnant
Y / N	Smoker	Y / N	Snore/sleep apnea	Y / N	Tuberculosis

Please explain all Y circles: ____

Doctor & Practice: ____

Please list any medication: ____

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