Victoria Park
ORTHODONTICS

Dr Frank Furfaro
Specialist Orthodontist
Phone: (08) 9361 0022 Fax: (08) 9361 0122
Email: reception@vicparkortho.com.au
www.vicparkortho.com.au

Thank you for attending our orthodontic practice. The following information is requested for record purposes and to supply past history of previous medical and dental treatment to enable thorough diagnosis and treatment planning. This and all records are protected by the Privacy Amendment Act 2000.

ALL SECTIONS OF THIS FORM MUST BE COMPLETE AND ACCURATE.

PATIENT'S NAME: (Mr, Mrs, Miss, Ms) …….. SEX: M ☐ F ☐ DATE OF BIRTH: ……..…….
HOME ADDRESS: …… POSTAL ADDRESS: ……...
……...
POST CODE: …….. PHONE: ……..……..... MOBILE: ……..……

FULL NAME OF MOTHER / GUARDIAN: (Mrs, Miss, Ms) ……
PHONE: …….. MOBILE: ……..
FULL NAME OF FATHER / GUARDIAN: ……..……
PHONE: …….. MOBILE: ……..
PERSON / PERSONS RESPONSIBLE FOR PAYMENT: ……..……..……
ADDRESS: ……...
…….. PHONE: ……..…… MOBILE: ……..……..…..
EMAIL ADDRESS ……..
RELATIONSHIP TO PATIENT: ……...
SIGNATURE OF PERSON RESPONSIBLE FOR PAYMENT: ……..

OTHER FAMILY MEMBERS WHO HAVE ATTENDED THE PRACTICE: ……..
……..……
REFERRED TO PRACTICE BY WHOM: ……..
NAME OF GENERAL DENTIST / SCHOOL DENTAL CLINIC: ……
TO WHICH HEALTH FUND DO YOU BELONG: ……..…. YEARS: ……

PRIVATE AND CONFIDENTIAL MEDICAL QUESTIONNAIRE

TO ENSURE OUR TREATMENT IS COMPATIBLE WITH YOUR PRESENT STATE OF HEALTH, PLEASE ANSWER THE FOLLOWING:-

	Y	N
I have confidential medical information which I do not wish to write down. I would prefer to speak to the orthodontist about this.	☐	☐
Are you receiving medical treatment at present? Please specify …….…...	☐	☐

……...
Name of your doctor …… PHONE: ……
Please list any medicines or tablets you are taking ……
……..……

	Y	N
Do you have an allergy or bad reaction to penicillin, local anaesthetic, other medicines, latex or rubber, metals, animals, plants or other substances?		
Details ……..…..…..….	☐	☐

Please indicate if any of the following is applicable.	Y	N		Y	N
Birth defects or hereditary problems ……	☐	☐	Do you bruise or bleed easily? ……..……	☐	☐
Rheumatic fever ……...	☐	☐	Any blood disorder ……..……..	☐	☐
Any heart complaint ……	☐	☐	Previous blood transfusion ……	☐	☐
Blood pressure changes ……	☐	☐	AIDS or HIV+ ……	☐	☐
Tonsils, adenoids or ear trouble ……	☐	☐	Hepatitis or jaundice or liver problems ……	☐	☐
Diabetes ……	☐	☐	Kidney problems ……..	☐	☐
Epilepsy ……	☐	☐	Previous general anaesthetic ……	☐	☐
Thyroid disease ……	☐	☐	Previous major surgery ……...	☐	☐
Tuberculosis ……	☐	☐	Any nervous system disorder ……	☐	☐
Problems with immune system ……	☐	☐	Mental health disturbance or depression ……	☐	☐
Cancer, tumour, radio or chemotherapy ……..	☐	☐	History of eating disorder (anorexia or bulimia) ……..	☐	☐
Arthritis or joint problems ……...	☐	☐	Are you pregnant? ……...	☐	☐
Osteoporosis ……	☐	☐	Do you smoke? ……	☐	☐
Are you using Bisphosphonates? ……..	☐	☐	Asthma ……..	☐	☐

	Y	N
I give consent to my treatment records being used for teaching purposes only……..……	☐	☐

In signing this form, I acknowledge that this represents an accurate medical history. I will also supply my orthodontist with any relevant changes to this history as required. All medical information will be treated with complete professional confidentiality.

Signed …… Date ……..……
(PARENT / GUARDIAN IF UNDER 18 YEARS)