HILLS
Orthodontics

New Patient Questionnaire (confidential)

Date:..

Full Name: Dr./Mr./Mrs./Ms./Miss……………...…………………………….................................. D.O.B: ....…...........

Address:……………………………………………………………………………………............................. Post Code:……………….............

Telephone: Home No:..........................……… Work No:..…….……………………………Mobile:……..........................………………..

E-mail address: ....…...........

Other members of family who have attended this orthodontic practice: ....………

Name of person responsible for account (if different to above): ....…...........

Postal Address (if different to above)………………………………………………………………………......................................…....

Signature..

Who recommended you to this practice? Family Member …… Friend …… Dentist …… Other (specify) ……………………………

Name of referrer: ……........

Your usual Dentist- Name & Suburb:...………..

Where you referred by: □ Hills District Netball Association □ Pennant Hills Tennis Centre □ Cherrybrook Netball Club

Medical History

List serious illnesses or conditions: ....………

Any Allergies? ....………

Are you currently taking any pills, tablets or medications of any kind? ....………

Are you at present receiving any medical or other health care?...………

Women: Are you pregnant or possibly pregnant?:………………………………………………………………………………………

Have you had, or been recommended to have, tonsils and/or adenoids removed? ………………………………………………………

Dental & Orthodontic History

Any heavy falls or blows to the face, or injuries to teeth or jaws?..…..

Previous Dental Treatment: Deep Fillings?… Root Therapy Treatment?…… Diagnosis of Gum Disease?…. Crowns/Bridges?......

Any teeth you or your dentist are particularly concerned about the health of?..…...................................

Any clicking, locking or pain from jaw joints?...…..

Are you a mouth breather?................................Any speech problems or previous speech therapy?..

Do you or did you suck your thumb or fingers after the age of 6 years?..…..

Any previous orthodontic treatment or consultation?...

What, if anything, is the orthodontic problem ***as you see it?*** Or what is your reason for attending this practice? ……………………

....…...

….………………………………...…..

Indicate **your** concern for correction of the orthodontic problem

1. Very concerned……….2. Concerned………….. 3. Indifferent………..4. Opposed…………