

Adult medical history

Personal details

Title* Ms Mrs Miss Mr Dr Mx Prof

First name*

Middle name

Last name*

Date of birth*

Gender*

Male Female Non-binary

Aboriginal or Torres Strait Islander*

Yes No

Address*

Suburb*

Postcode*

Home phone

Mobile phone

Work phone

Email*

Occupation

Preferred contact Home Mobile Work

Medicare details

Medicare Number*

Expiry date*

Ref number

Emergency Contact

Full Name*

Relationship to Patient*

Email

Phone*

Doctor details

Medical practitioner

Family dentist

Referring dentist

Trauma

Have you ever had an accident involving teeth or jaw?*

Yes No

Have you ever had clicking, noises, or pain in your jaw joints?*

Yes No

Medical history

This may affect your orthodontic treatment. Please mark the correct answer and provide details when necessary.

Allergy to latex*

Yes No

Asperger's, Autism, ADD, ADHD*

Yes No

If yes, specify

Asthma*

Yes No

Anesthesia complications*

Yes No

Diabetes, Epilepsy, Goitre etc*

Yes No

Prolonged bleeding after injury*

Yes No

Are you taking any medication*

Yes No

Other

Yes No

Do you require antibiotic cover for dental procedures*

Yes No

Do you experience anxiety related to medical visits?*

Yes No

Heart or Kidney Disease*

Yes No

Allergies*

Yes No

Blood Pressure (High or Low)*

Yes No

Psychiatric or Psychological care*

Yes No

Is there a possibility that you could be pregnant*

Yes No

Serious operation*

Yes No

Hepatitis or HIV*

Yes No

Congenital heart disease or rheumatic fever*

Yes No

Prone to fainting*

Yes No

Do you have a disability or additional support needs?*

Yes No

Further details, if necessary

Sleep disturbance scale

At Smile Team Orthodontics we believe that all of our clients (both children and adults) should be screened before they consider orthodontic treatment because our treatment recommendations may differ in the presence of sleep apnea.

What is Obstructive Sleep Apnea? Sleep Apnea occurs when the walls to the throat close during sleep, causing breathing to stop. Once the brain registers that it is not breathing, the sleeper usually wakes up, rouses and the throat opens again, then they drift back to sleep. The person affected by sleep apnea, in most cases, does not realise they have even woken. It also causes decreased Oxygen Intake. This means the brain, heart and nervous system are not receiving their required time to rest and oxygenate. The pattern can repeat itself hundreds of times every night. One of the side effects of Sleep Apnea is Cardiac Problems. Also drivers with sleep apnea have 8 times the risk of car accidents.

Sudden Cardiac Death during sleep occurs more commonly in patients who have Obstructive Sleep Apnea.

Epworth Sleepiness Scale – for 17 years and older. Use the following scale to choose the most appropriate for each situation.

<p>Sitting and reading*</p> <p><input type="checkbox"/> Would never doze or sleep <input type="checkbox"/> Slight chance of dozing or sleeping</p>	<p><input type="checkbox"/> Moderate chance of dozing or sleeping <input type="checkbox"/> High chance of dozing or sleeping</p>
<p>Watching TV*</p> <p><input type="checkbox"/> Would never doze or sleep <input type="checkbox"/> Slight chance of dozing or sleeping</p>	<p><input type="checkbox"/> Moderate chance of dozing or sleeping <input type="checkbox"/> High chance of dozing or sleeping</p>
<p>Sitting inactive in a public space*</p> <p><input type="checkbox"/> Would never doze or sleep <input type="checkbox"/> Slight chance of dozing or sleeping</p>	<p><input type="checkbox"/> Moderate chance of dozing or sleeping <input type="checkbox"/> High chance of dozing or sleeping</p>
<p>Being a passenger in a motor vehicle for an hour or more*</p> <p><input type="checkbox"/> Would never doze or sleep <input type="checkbox"/> Slight chance of dozing or sleeping</p>	<p><input type="checkbox"/> Moderate chance of dozing or sleeping <input type="checkbox"/> High chance of dozing or sleeping</p>
<p>Lying down in the afternoon*</p> <p><input type="checkbox"/> Would never doze or sleep <input type="checkbox"/> Slight chance of dozing or sleeping</p>	<p><input type="checkbox"/> Moderate chance of dozing or sleeping <input type="checkbox"/> High chance of dozing or sleeping</p>
<p>Sitting and talking to someone*</p> <p><input type="checkbox"/> Would never doze or sleep <input type="checkbox"/> Slight chance of dozing or sleeping</p>	<p><input type="checkbox"/> Moderate chance of dozing or sleeping <input type="checkbox"/> High chance of dozing or sleeping</p>
<p>Sitting quietly after lunch (no alcohol)*</p> <p><input type="checkbox"/> Would never doze or sleep <input type="checkbox"/> Slight chance of dozing or sleeping</p>	<p><input type="checkbox"/> Moderate chance of dozing or sleeping <input type="checkbox"/> High chance of dozing or sleeping</p>
<p>Stopped for a few minutes in traffic while driving*</p> <p><input type="checkbox"/> Would never doze or sleep <input type="checkbox"/> Slight chance of dozing or sleeping</p>	<p><input type="checkbox"/> Moderate chance of dozing or sleeping <input type="checkbox"/> High chance of dozing or sleeping</p>

Referral

<p>Have you had another member of your family treated in this practice?*</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>If YES, what is the family member's name?</p>	
<p>Do you have a referral?*</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p>

Have you had a dental check up in the last 12 months?*

Yes No

How did you hear about Smile Team Orthodontics? *

Please select ONE that is the most relevant to you.

- | | | |
|---|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Cinema | <input type="checkbox"/> Invisalign | <input type="checkbox"/> Facebook |
| <input type="checkbox"/> Referring Dentist | <input type="checkbox"/> Local Event | <input type="checkbox"/> Instagram |
| <input type="checkbox"/> Friend/Relative/Staff Member | <input type="checkbox"/> Radio | <input type="checkbox"/> Television |
| <input type="checkbox"/> Google or Online Search | <input type="checkbox"/> Signage | <input type="checkbox"/> Website |
| <input type="checkbox"/> Other (If Other, please specify) | | |
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Person responsible for paying for the orthodontic treatment

Name of person paying for treatment - Same as client details*

Yes No

If NO please enter details below.

Title* Ms Mrs Miss Mr Dr Mx Prof

First name*

Last name*

Address

Postcode

Phone*

Email*

Relationship to client

Date

Your Health Information & Our Privacy Policy

Our practice respects your right to privacy. It is important that you understand the purpose for which we collect details about you and your health, as well as how this information is used at our practice and to whom this information might be disclosed. More detailed information is set out in our Privacy Policy. If you would like a copy of the policy please ask our staff. The information we collect will be used for the purpose of providing treatment to you. Personal information such as your name, address, telephone numbers, email address and health insurance details will also be used for the purpose of billing and processing payments. Unless you tell us you do not want to receive information from us, we will also use these details to keep you updated about our services and advise you of other products and services relevant to your dental and general health. Unless required to do so by court order or other legislative requirement, we will only collect, use and disclose your health information for the purposes of assessing, advising and treating you. We may also use parts of your health information for staff training, professional development, quality improvement and dental health research. Your personal identity will not be disclosed without your consent to do so or, if this is not possible, with the approval of an ethics committee. Your patient history, treatment records, x-rays and any other material relevant to your treatment are kept in both a written form and in electronic clinical information systems. We have security measures in place to protect this information against unauthorised access or use and damage, theft or other loss. We may use contracted external providers to assist us with this data storage, access and use.

These providers are based in Australia. You may inspect or request copies of your treatment records at any time, or seek an explanation from the Orthodontist. If you want copies, a fee may apply. If you require a detailed explanation of your records or a written summary, a consultation fee or other charge may apply. It is important that the information we hold about you remains accurate. Please advise our staff if your contact or medical details ever change. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

Provide an updated copy of the practice's Medical History Form that supports the practice to identify the patient groups as potentially 'at risk', as documented in the practice's Governance for Safety and Quality Policy:

- People with diverse backgrounds.
- People from a different cultural or linguistic background.
- People from a low socio-economic background.
- People with limited numeracy and literary capacity.
- Medically compromised patients.
- People with addiction.
- Patients with recognised deterioration in physical and/or mental or cognitive health.

Date*

Please sign here:
