Child medical history

Client details

First name* Middle name

Last name* Date of birth*

Gender* ☐ Male ☐ Female ☐ Non-binary

Address*

Suburb* Postcode*

Phone*

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 the orthodontic treatment. Please circle the correct answer and provide details when necessary.

Allergy to latex * ☐ Yes ☐ No

Heart or Kidney Disease * ☐ Yes ☐ No

Asperger's, Autism, ADD, ADHD * ☐ Yes ☐ No

Allergies * ☐ Yes ☐ No

Asthma * ☐ Yes ☐ No

Blood pressure * ☐ Yes ☐ No

Anesthesia complications * ☐ Yes ☐ No

Psychiatric or Psychological care * ☐ Yes ☐ No

Diabetes, Epilepsy, Goitre etc * ☐ Yes ☐ No

Is there a possibility that you could be pregnant * ☐ Yes ☐ No

Prolonged bleeding after injury * ☐ Yes ☐ No

Serious operation * ☐ Yes ☐ No

Are you taking any medication * ☐ Yes ☐ No

Hepatitis or HIV * ☐ Yes ☐ No

Other * ☐ Yes ☐ No

Congenital heat disease or rheumatic fever * ☐ Yes ☐ No

Do you require antibiotic cover for dental procedures * ☐ Yes ☐ No

Prone to fainting * ☐ 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 effected 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.

EXTRACT FROM THE BRUNI SCALE - for 16 years and under. This questionnaire will allow your orthodontist to have a better understanding of the sleep-wake rhythm of your child and of any problems in his/her sleep behavior. Answer every question; in answering, consider each question as pertaining to the past 6 months of the child's life.

Please answer the questions by circling or striking the number 1 to 5.

The child has difficulty in breathing during the night *

- ☐ Never
- ☐ Occasionally (once or twice per month or less)
- ☐ Sometimes (once or twice per week)
- ☐ Often (3 or 5 times per week)
- ☐ Always (daily)

The child gasps for breath or is unable to breathe during sleep *

- ☐ Never
- ☐ Occasionally (once or twice per month or less)
- ☐ Sometimes (once or twice per week)
- ☐ Often (3 or 5 times per week)
- ☐ Always (daily)

The child snores *

- ☐ Never
- ☐ Occasionally (once or twice per month or less)
- ☐ Sometimes (once or twice per week)
- ☐ Often (3 or 5 times per week)
- ☐ Always (daily)

Referral

Have you had another member of your family treated in this practice? * ☐ Yes ☐ No

If YES what is the family member's name? _____

Do you have a referral? * ☐ Yes ☐ No

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 may apply and provide details when necessary in box below.

- ☐ Google
- ☐ Family/Referring Dentist
- ☐ TikTok
- ☐ Relative
- ☐ Radio – Power FM Bowral/South Coast
- ☐ Television Ad
- ☐ Radio – 2ST Bowral
- ☐ Instagram
- ☐ Specialist
- ☐ Bus Stop
- ☐ Other
- ☐ Invisalign
- ☐ Facebook
- ☐ Sibling
- ☐ Friend
- ☐ Radio – i98 FM Illawarra
- ☐ Smile Team Website
- ☐ Sign
- ☐ Member of Staff
- ☐ Email
- ☐ Crown Mall Wollongong

If Specialist, please specify _____

If Friend, please name _____

If Member of Staff, please specify _____

If Relative, please name _____

If Other, please specify _____

Parent/ Guardian

Complete the information for Parents/Guardians overseeing the client's appointments, scheduling, and treatment. Alternatively, See the split payment options outlined in the billing section

Parent/Guardian 1

Title

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Mx ☐ Mst ☐ Prof ☐ Other _____

First name* _____ Last name* _____

DOB _____ Phone * _____

Address* _____

Email * _____ Relationship to client _____

Are you responsible for the finances? *

☐ Yes ☐ No

Are you the primary carer? *

☐ Yes ☐ No

Parent/Guardian 2

Title

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Mx ☐ Mst ☐ Prof ☐ Other _____

First name* _____ Last name* _____

DOB _____ Phone * _____

☐ Address is same as Parent/Guardian 1.

Address* _____

Email * _____ Relationship to client _____

Are you responsible for the finances? *

☐ Yes ☐ No

Are you the primary carer? *

☐ Yes ☐ No

Parent/ Guardian (cont)

For billing purposes will payments be split between responsible parties? *

☐ Yes ☐ No

If yes please complete below details of the second party responsible for the account.

Name _____ Email _____

DOB _____ Phone _____

Address _____

Is this party authorized to receive information regarding the client's treatment and bookings?

☐ Yes ☐ No

Date _____

Please sign here _____