North Sydney Orthodontics
New patient questionnaire

Patient Details

Fax 02 9954 5122

Surname_____Title_____

First Names_____ Date of Birth_____

Home Address_____

Suburb_____ Post Code_____

☎ Home _____ ☎ Work _____☎ Mobile _____

Email_____

Of which Health Fund are you a member? _____

Your Dentist _____Suburb _____

Please describe briefly the concerns you have with your teeth positions and what you would like to change about their appearance.

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How did you hear about us? (Please circle)

Online Yellow Pages, Online True local, Google Adwords, Yahoo Ads Invisalign directory
Online Search engine, Other online directory …….
School Bulletins/ Notices, Printed Yellow Pages. Newspaper ad, Flyer

I was recommended by _____(Friend / Relative / Dentist)

Emergency contact person _____Phone number _____

Your Occupation _____

Employer _____

If the patient is a minor please state

Name of the legal guardian (for consent) _____

Mother's name _____

Father's name _____

Other Siblings _____

Medical details

Patient Surname _____ First name _____

Have you ever had any of the following? Please tick those that apply:

❑ Anaemia	❑ Fainting	❑ Pacemaker
❑ Artificial joints	❑ Glaucoma	❑ Radiation Therapy
❑ Asthma	❑ Heart Disease	❑ Respiratory problems
❑ Blood Disease	❑ Heart Murmur	❑ Rheumatic fever
❑ Cancer	❑ Hepatitis A B C	❑ Sinus problems
❑ Dizziness	❑ Jaundice	❑ Stroke
❑ Epilepsy	❑ Kidney Disease	❑ Tuberculosis
❑ Excessive Bleeding	❑ Liver Disease	❑ Tumours
❑ Diabetes	❑ HIV / AIDS	❑ Psychological Disorders

ANY OTHER SERIOUS ILLNESS?

_____

SURGERY or OPERATIONS?

_____

What DRUGS do you take regularly (medications pills, injections, tablets, ointments, etc)?

_____

Please state any ALLERGIES you have

_____

Have you ever had any ADVERSE REACTION TO MEDICAL or DENTAL TREATMENT?

_____

If you are PREGNANT - What is your due date?_____

Name of Medical Doctor_____Phone Number_____

Are you a SMOKER _____

Do you consent to the use of anonymised photographs for teaching, research, or publications that the Orthodontist may author? Y / N

Signature of Patient (Parent or Guardian)_____Date_____

If you are not the patient please state :

Surname _____First name_____

If you have an OPG x-ray or Lateral Cephalogram x-ray less than 1 year old please bring it with you

$50.00 penalty may be charged for appointments missed or cancelled with less than 24 hours notice