

Townsville Orthodontic Specialists

The following information is requested to enable us to give you our best attention.
Each question is relevant to modern dental practice and is confidential.

PATIENT MEDICAL HISTORY CONSENT FORM

Name _____

(Indicate yes or no and give details where appropriate)	Y	N	Details
Are you being treated by your doctor at present?	<input type="checkbox"/>	<input type="checkbox"/>	-----
Are you taking any tablets, medicines or drugs at present?	<input type="checkbox"/>	<input type="checkbox"/>	-----
Have you been a hospital patient in the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	-----
Do you require antibiotic cover before dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	-----
Are you allergic to any drug or medicine?	<input type="checkbox"/>	<input type="checkbox"/>	-----
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	-----
Females, are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	-----

	Y	N		Y	N		Y	N
Heart Complaint	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Implant	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Valve Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>						

Any other serious condition or disability _____

Is there any issue regarding this medical history which you wish to discuss in private with your orthodontist: YES NO

Do you consent for your medical history, x-rays, photos, treatment history to be shared with other affiliated health professionals e.g. Oral Surgeon, General Dentist including the transferring of your records to another Orthodontic Specialist to continue your treatment. YES NO

Do you consent to having your photos being utilized for training purposes and marketing tools for the practice inclusive of patient newsletter and facebook. YES NO

DECLARATION

I have completed this form to the best of my knowledge and declare this to be an accurate medical history of the above mentioned patient. On future visits I will advise of any changes to the history.

Signature _____ Date _____
(Patient or Parent/Guardian if under 18 years)

PRIVATE HEALTH INSURANCE

Townsville Orthodontic Specialists offers payment plans to all orthodontic patients. Specific information about your Private Health Insurance is required to assist you with your health fund rebates when we structure payment plans.

Please contact your Private Health Insurance Company for the following information and bring this with you to your initial consultation.

1. NAME OF HEALTH INSURANCE COMPANY: _____
2. NAME OF THE LEVEL OF COVER: _____
3. LIFETIME LIMIT: _____
4. YEARLY LIMIT: _____
5. PERCENTAGE OF EACH ACCOUNT PAID BY INSURER: _____
6. ANNIVERSARY DATE: _____