Adult medical history

Personal details

Title

☐ Ms ☐ Mr

☐ Mrs ☐ Dr

☐ Miss ☐ Mx

☐ Prof

First name* Middle name

Last name* Date of birth*

Gender* ☐ Male ☐ Female ☐ Non-binary

Address*

Suburb* Postcode*

Home phone Mobile phone

Work phone Email *

Occupation

Preferred contact ☐ Home ☐ Mobile ☐ Work

Medicare details

Medicare Number * Reference Number *

Expiry date *

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

Allergy to latex *
☐ Yes ☐ No

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

If yes, please specify

Asthma *
☐ Yes ☐ No

Anesthesia complications *
☐ Yes ☐ No

Diabetes, Epilepsy, Goitre etc *
☐ Yes ☐ No

Heart or Kidney Disease *
☐ Yes ☐ No

Allergies *
☐ Yes ☐ No

Blood pressure *
☐ Yes ☐ No

Psychiatric or Psychological care *
☐ Yes ☐ No

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

Medical history (cont)

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

Prone to fainting *
☐ Yes ☐ No

Do you require antibiotic cover for dental procedures *
☐ 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.

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

Sitting and reading *

☐ Would never doze or sleep
☐ Slight chance of dozing or sleeping
☐ Moderate chance of dozing or sleeping
☐ High chance of dozing or sleeping

Watching TV *

☐ Would never doze or sleep
☐ Slight chance of dozing or sleeping
☐ Moderate chance of dozing or sleeping
☐ High chance of dozing or sleeping

Sitting inactive in a public space *

☐ Would never doze or sleep
☐ Slight chance of dozing or sleeping
☐ Moderate chance of dozing or sleeping
☐ High chance of dozing or sleeping

Being a passenger in a motor vehicle for an hour or more *

☐ Would never doze or sleep
☐ Slight chance of dozing or sleeping
☐ Moderate chance of dozing or sleeping
☐ High chance of dozing or sleeping

Lying down in the afternoon *

☐ Would never doze or sleep
☐ Slight chance of dozing or sleeping
☐ Moderate chance of dozing or sleeping
☐ High chance of dozing or sleeping

Sitting and talking to someone *

☐ Would never doze or sleep
☐ Slight chance of dozing or sleeping
☐ Moderate chance of dozing or sleeping
☐ High chance of dozing or sleeping

Epworth Sleepiness Scale (cont)

Stopped for a few minutes in traffic while driving *

- ☐ Would never doze or sleep
- ☐ Slight chance of dozing or sleeping
- ☐ Moderate chance of dozing or sleeping
- ☐ High chance of dozing or sleeping

Sitting quietly after lunch (no alcohol) *

- ☐ Would never doze or sleep
- ☐ Slight chance of dozing or sleeping
- ☐ Moderate chance of dozing or sleeping
- ☐ High chance of dozing or sleeping

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.

- ☐ Cinema
- ☐ Friend/Relative/Staff Member
- ☐ Invisalign
- ☐ Radio
- ☐ Social Media
- ☐ Website
- ☐ Referring Dentist
- ☐ Google or Online Search
- ☐ Local Event
- ☐ Signage
- ☐ Television
- ☐ Other

If Other, please specify

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 ☐ Mr ☐ 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.

Please sign here