# Child medical history

## Client 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*

Phone*

Medical practitioner

Family dentist

Referring dentist

## Medicare details

Medicare Number * Reference Number *

Expiry date *

## 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

Prolonged bleeding after injury * ☐ Yes ☐ No

Are you taking any medication * ☐ Yes ☐ No

Other * ☐ Yes ☐ No

Prone to fainting * ☐ 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

Serious operation * ☐ Yes ☐ No

Hepatitis or HIV * ☐ Yes ☐ No

Congenital heat disease or rheumatic fever * ☐ 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.

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.

- ☐ 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

## 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

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr ☐ Mx ☐ Prof

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

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr ☐ Mx ☐ Prof

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 responsibly parties or third parties?

☐ Yes ☐ No

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

Name Email

DOB Phone

Address

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**