NEW CLIENT REGISTRATION FORM

Western ORTHO
SPECIALIST ORTHODONTISTS

First name: _____Last name: _____

Preferred name: _____Date of birth: _____

Gender: _____ Preferred Pronouns: ☐She/Her ☐He/His ☐They/Them ☐Other_____

Home address: _____

Suburb: _____Postcode: _____

Phone (home): _____Phone (work/mobile): _____

Email: _____

Name of person responsible for fees: _____ Relationship to patient:_____

School attended or Occupation: _____

Do you have dental insurance? ☐ Yes ☐No Which fund? _____

How did you hear about us? ☐Friend/family. Who may we thank for referring you? _____

☐Referred by dentist ☐ Walked/drove past

☐ Google search ☐ Other _____

Please complete the following if patient is under 18 years of age:

Parent/Guardian names: _____

Parents address (if different from child): _____

Suburb: _____Postcode:_____ Phone: _____

YOUR DENTAL HEALTH

Name of general dentist: _____

Dentist address: _____

When was your last dental check-up? _____

What is your main concern with your teeth? _____

Is there any history of injuries to your face, mouth or teeth? .....☐ Yes ☐ No

Have you had previous orthodontic treatment? .....☐ Yes ☐ No

Has anyone in your family had orthodontic treatment? .....☐ Yes ☐ No

Have you ever sucked your thumb or fingers? If yes, until what age? .....☐ Yes ☐ No

Have you ever had any problems with dental treatment in the past? .....☐ Yes ☐ No
If YES, please describe _____

[Please TURN OVER and complete the medical questionnaire]

YOUR HEALTH

Have you ever had any of the following?

Asthma/breathing problems ..... ☐ Yes ☐ No
High blood pressure ..... ☐ Yes ☐ No
Heart problems ..... ☐ Yes ☐No
Rheumatic fever ..... ☐ Yes ☐No
Autism spectrum disorder ..... ☐ Yes ☐No
ADD/ADHD ..... ☐ Yes ☐No
Diabetes ..... ☐ Yes ☐No
Epilepsy ..... ☐ Yes ☐No
Excessive bleeding or blood disorder ..... ☐ Yes ☐No
Tuberculosis ..... ☐ Yes ☐No
Kidney/liver problems ..... ☐ Yes ☐No
Thyroid problems ..... ☐ Yes ☐No
Arthritis or joint problems ..... ☐ Yes ☐No
Hepatitis ..... ☐ Yes ☐No
HIV/AIDS ..... ☐ Yes ☐No
Mental health issues ..... ☐ Yes ☐No
Please list any other illness not mentioned _____

Are you currently taking any medicines or tablets? ..... ☐ Yes ☐No
If YES, please give details _____

Have you ever stayed in hospital or had a general anaesthetic? ..... ☐ Yes ☐No
If YES, please give details _____

Do you have any prosthetic implants including artificial joints and heart valves?..... ☐ Yes ☐No

Are you allergic to any products or medicines?..... ☐ Yes ☐No

Are you allergic to latex? ..... ☐ Yes ☐No

Females, are you pregnant? ..... ☐ Yes ☐No

Do you smoke/vape? ☐ Yes ☐ No How many per day? ..... Would you like to stop? ☐ Yes ☐No

I have completed this questionnaire to the best of my knowledge and understand that failure to make a full disclosure may put me at undue medical risk. I understand that at times my dental records (notes, x-rays, photographs, models) may need to be sent to other dental practitioners to aid in my treatment, and I consent to this.

Our practice uses Heidi Health AI to help record and transcribe my consultation so that accurate notes can be added to my medical record. I understand that this tool only assists with documentation and does not make clinical decisions. My clinician is fully responsible for my care. I understand that my information is kept confidential and secure, and that no audio recordings are stored during this process.

Signed: _____

Please print name: _____

Relationship to patient (if not self): _____

Date: _____