The Bachmayer Orthodontic Clinic
Smiles are our specialty

DENTAL HISTORY

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing orthodontic care. All information will be kept completely confidential.

Patient Name: _____ **Date of Birth:** _____

Doctor (GP): _____ **GP Phone N^{o}:** _____

Dentist: _____ **Dentist Suburb:** _____

Have orthodontic appliances been worn previously? No ☐ Yes ☐

If yes, please provide details _____

Are you in a health fund? No ☐ Yes ☐

If yes, name of fund _____

Has any other member of the family attended our surgery? No ☐ Yes ☐

If yes, please provide name _____

ORTHODONTIC CONCERNS

What are your orthodontic concerns:

☐ Irregular teeth
☐ Speech impediment
☐ Pain in the face or jaw joints
☐ Inability to chew effectively
☐ Missing teeth
☐ Facial appearance

DENTAL TRAUMA

Have any accidents occurred that caused any of the following:

☐ Tooth loss
☐ Facial fractures
☐ Disturbance to jaw joints
☐ Chipping of any teeth
☐ Discolouration of any teeth

Do you clench/grind your teeth? No ☐ Yes ☐
Do you have a nail biting habit? No ☐ Yes ☐
Do you suck your thumb/fingers? No ☐ Yes ☐ If stopped, at what age? _____

Have you ever experienced:

Jaw/joint pain No ☐ Yes ☐
Jaw/joint noises No ☐ Yes ☐
Jaw/joint popping No ☐ Yes ☐
Jaw locking No ☐ Yes ☐
Jaw clicking No ☐ Yes ☐
Ringing in ears No ☐ Yes ☐

Please complete over page

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MEDICAL HISTORY

Do you have any notable medical or behavioural conditions? No ☐ Yes ☐
Please provide details _____

Are you currently taking any medication/s? No ☐ Yes ☐
Please provide details _____

Do you require prophylactic antibiotic cover for invasive dental treatment? No ☐ Yes ☐
Please provide details _____

Have you ever been hospitalised? No ☐ Yes ☐
Please provide details _____

Have you had your tonsils/adenoids removed? No ☐ Yes ☐
Please provide details _____

Have/are you currently undergoing speech therapy? No ☐ Yes ☐
Please provide details _____

Do you have any allergies/hayfever? No ☐ Yes ☐
Please provide details _____

Please tick if you have a history of any of the following conditions:

- ☐ Heart conditions
- ☐ Heart surgery
- ☐ Haemophilia/blood disorder
- ☐ Rheumatic fever
- ☐ Tonsillitis
- ☐ Diabetes
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Bone disorders
- ☐ Endocrine disorders
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Hepatitis A B C ***(please circle)***
- ☐ HIV/AIDS
- ☐ Herpes (fever/blisters)
- ☐ Asthma
- ☐ Mouth breather
- ☐ Hives/rash
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Developmental disorders
- ☐ Growth disorder
- ☐ Frequent headaches
- ☐ Nervous/anxious
- ☐ Fainting episodes
- ☐ Drug addiction
- ☐ Cancer

I certify that the above medical history is accurate at this time. If there are future changes, I will inform the office.

I consent to my records being used for education and training purposes: No ☐ Yes ☐

Signature: _____ **Date:** _____
(Parent/guardian if under 18 years of age)

Please complete over page