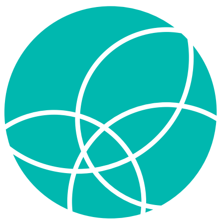

symmetry orthodontics

Dr Jamie Galbraith
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Specialist Orthodontist

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Alexandra Headland QLD 4572
Provider No. 2804468T

MEDICAL AND DENTAL HISTORY FORM

Patient Name Dr/Mr/Mrs/Ms/Miss/Mast | Date of Birth / / | Sex M / F

Parent/Guardian Name Dr/Mr/Mrs/Ms (if patient under 18 years)

Postal Address | Suburb/Town | Postcode

Mobile Number | Home Number | Work Number

Email Address

Patient School or Occupation | Private Health Insurance (Please specify fund)

Emergency Contact Name | Contact Number | Relationship to Patient:

Do you have or have ever had any of the following?

Condition	
Heart Problems	Y / N
Heart Surgery / Pacemaker	Y / N
Artificial heart valve	Y / N
Joint Replacement	Y / N
High Blood Pressure	Y / N
Low Blood Pressure	Y / N
Rheumatic Fever	Y / N
Asthma	Y / N
Hepatitis A, B, C	Y / N
Radiation Treatment	Y / N
Cancer Therapy	Y / N
Liver Problems	Y / N
Kidney Problems	Y / N
Tuberculosis	Y / N
HIV/AIDS	Y / N
Diabetes	Y / N
Epilepsy	Y / N
Osteoporosis	Y / N

Do you have or have ever had a reaction to the following?

Item	
Latex	Y / N
Penicillin / Amoxiciliin	Y / N
Tetracycline	Y / N
Dental Anaesthetics	Y / N
Aspirin	Y / N
Other:	Y / N

Question	
Do you smoke?	Y / N
Do you take recreational drugs?	Y / N
Do you take vitamins/supplements?	Y / N
Do you require antibiotic cover prior to treatment?	Y / N
Are you pregnant?	Y / N
Are you nursing?	Y / N

Are you being treated by a doctor? Please list all medications and conditions you are currently being treated for:

____

____

____

To help us meet your needs please take some time to answer the questions below regarding your dental health and experiences.

Do you have any current or future concerns about your dental health? Can you describe these?

____

____

What have your previous dental experiences been like?

____

____

Is there anything else you would like us to know?

____

____

Do you see a General Dentist? Please specify: ______________________________

When was you last General Dental check-up? ______________________________

How often do you have dental examinations? ______________________________

I consent to SMS and Email reminders for future appointments: Y / N

I consent to patient's name being displayed on iPad check in station: Y / N

How did you hear about Symmetry Orthodontics? Please specify.

Friend? ____

Dentist? ____

Website? ____

Other? ____

____

Name   Signature   Date