

**Please complete all the sections and add details as necessary.**

**Patient's Name** ..... **Date of Birth** .....

Names(s) of any sibling(s) already under treatment with us.....

If patient is a minor, Parent's first name(s).....

**Address** ..... **Telephone:** (Home)  
(Work)  
(Mobile)

**Dentist**..... Who recommended this practice?

Your Reason for Seeking  
Orthodontic Treatment .....

**This next section is a confidential medical questionnaire. It is important that all questions are answered correctly. Please add relevant details the space underneath the line.**

1. Have you attended a doctor recently? ..... Yes / No
2. Have you ever been an in-patient in hospital? ..... Yes / No
3. Do you take medicine for anything at present? ..... Yes / No
4. Have you ever had a long course of medicine? ..... Yes / No
5. Do you have any heart problems? ..... Yes / No
6. Do you have any lung or breathing problems? ..... Yes / No
7. Do you have any bleeding problems? ..... Yes / No
8. Are you allergic to anything? ..... Yes / No
9. Have you ever had orthodontic treatment? ..... Yes / No
10. Do you have or have you ever had a clicking jaw? ..... Yes / No
11. Have you ever suffered a blow to the front teeth? ..... Yes / No
12. Do you now or did you ever suck your thumb / finger / soother ?..... Yes / No
13. Do you play any music instrument? ..... Yes / No
14. When was the last check-up by your dentist .....

To the best of my knowledge, all these answers are correct

Signed.....  
Patient / Parent / Guardian

Date.....