VIRTUOSUM ORTHODONTICS

ADULT PATIENT INFORMATION AND MEDICAL HISTORY FORM

Title_____ First Name_____ Surname_____

Preferred name_____

Gender ○ MALE ○ FEMALE Date of Birth Age_____

Patients Occupation_____

Reason for seeking Orthodontic Treatment_____

_____

Past Orthodontic Consultation ○ YES/○ NO Past Orthodontic Treatment (braces?)_____

Are you interested in ☐ Braces ☐ Invisalign ☐ Lingual Braces

Patient Dentist name _____

Have you had a recent check up and/or clean with your dentist? ○ YES/○ NO

Who can we thank for referring you?

☐ Dentist ☐ Other Specialist ☐ Staff Member

☐ Dental Therapist/Hygienist ☐ Our Website ☐ Internet

☐ Facebook ☐ Instagram ☐ Signage

Friend/Family member name_____

Patient Medical History (Please tick)

☐ Asthma ☐ Heart murmur ☐ Heart Disease ☐ Antibiotics required before treatment

☐ Diabetes ☐ HIV/AIDS ☐ Hepatitis ☐ Epilepsy

☐ Kidney Disease ☐ Bone Disorders ☐ Growth Problems ☐ Blood Pressure

☐ Excessive Bleeding ☐ Anxiety ☐ Headaches ☐ Allergies

☐ Facial/Dental Trauma

☐ Other_____

Please explain ticked boxes if required_____

Current Medication _____

Have you had Biophosphonate therapy in the last 6 months?_____

Person responsible for fees: ☐ Self ☐ Other- Relationship to patient_____

Contact Details for account holder:

Title:_____ Name:_____

Address:_____

Post Code:_____ Home phone:_____ Mobile:_____

Work Phone:_____ Email:_____

Correspondence to be sent to: ☐ Self ☐ Other ☐ Both

Are you insured for Orthodontic extras? ◯ YES_____/ ◯ NO

The information that I have provided is complete and correct to the best of my knowledge.

Patient Signature:_____ Name:_____ Date:_____

Privacy Policy

Virtuosum Orthodontics respects your right to privacy and it has systems and processes in place to ensure it complies with the Australian Privacy Principles (APPs).
We collect information about you for the purpose of providing health services to you. In addition, personal information such as your name, address and health insurance details are used for the purpose of addressing accounts to you, as well as processing payments and writing to you about our services and any issues affecting your health care. We may collect information about you from third parties providing the collection of that information is necessary in the context of your care.
We may disclose your health information to other health care professionals, or require it from them if, in our judgement, it is necessary in the context of your care.
We may also use parts of your health information for research purposes, in study groups or at seminars; As part of its electronic records system, the practice may rely on cloud storage providers located outside of Australia. The practice will ensure that any offshore transfer complies with its obligations under the APP's.

Please sign this form as confirmation that you have read and understood the above information and consent to the collection and use of your health information.

Patient Signature:_____ Name:_____Date:_____

Authority to request/refer records to Heath Care Professionals

Virtuosum Orthodontics may need to request or provide records from or to your previous or current Dentist or Specialist to assist with your Orthodontic treatment planning. Such records may include, but not limited to medical cares and treatment, illness or injury, dental and orthodontic history, medical history, consultation, prescriptions, X-rays and models.

Patient Signature:_____ Name:_____Date:_____