

# ***Dr. Peter Grant - Orthodontist - B.D.SC., M.D.SC.***

## **Patient Records**

*Dear Patient,*

*Welcome to our practice. Please complete the following sections on this side of the form. All information is held in the strictest confidence. Please ask for assistance if required.*

**Gender of Patient** (please circle): Female / Male

**Full Name of Patient:** ..... **Date of Birth:** .....

**Address:** .....

**Suburb:** ..... **State:** ..... **Post Code:** .....

**Telephone: Mobile** ..... **Work:** .....

**Email:** .....

**Patient's Occupation / Name of School:** .....

**Name of Person Paying Fees:** .....

**Relationship to Patient:** ..... **Name of Health Fund:** .....

**Does your Health Fund cover Orthodontics?:** .....

**Name of Parents:** .....

**Name of Dentist:** ..... **Name of Doctor:** .....

**Who referred you?** .....

**Has the patient ever had** (please circle if applicable)?: Orthodontic Treatment / Orthodontic Opinion

## **Medical History**

Are you taking any medicines, pills, tablets or drugs (whether prescribed by a doctor or not)?

If applicable, please list: .....

Do you have any allergies or adverse reactions to any medications? If applicable, please list:

.....

Do you have any longstanding illness or condition? If applicable, please list:

.....

Have you ever had (please tick if applicable)?:

- |                             |   |
|-----------------------------|---|
| • Rheumatic Fever .....     | • Diabetes .....                            |
| • Heart Disease .....       | • Epilepsy .....                            |
| • High Blood Pressure ..... | • Cancer or other malignancy .....          |
| • Low Blood Pressure .....  | • Any reaction to General Anaesthetic ..... |
| • Asthma .....              | • Any reaction to Local Anaesthetic .....   |

Could you possibly be carrying the AIDS virus and/or Hepatitis virus?: .....

If you are female, are you pregnant (please tick if applicable)?: .....

**SIGNATURE:** ..... **DATE:** .....  
(Parent/Guardian, if applicable)

*Office Use Only: X-Rays provided? Yes / No*