**WELCOME TO THE PRACTICE**

Patient's Surname ______________________________

Patient's First Name ______________________________

Title: Mr / Mrs / Miss / Ms / Master / Dr __________

Preferred Name ______________________________

Date of Birth ______________________________ Sex Male ☐ Female ☐

Parent / Guardian Name ______________________________

Home Address ______________________________

Suburb ______________________________ Postcode ______________

Mailing Address (if different) ______________________________

Suburb ______________________________ Postcode ______________

Email Address ______________________________

Phone: Home ______________________________ Phone: Work ______________________________

Phone: Mobile ______________________________

Occupation ______________________________

Referred by ______________________________

Usual Dentist ______________________________

Person Responsible For Payment

Self ☐ Mother + Father ☐ ______________________________

Mother ☐ ______________________________ Father ☐ ______________________________

Other ☐ ______________________________

Dental Health Fund ______________________________

Medicare Number ______________________________ Patient Number ____ Expiry Date ______________

What is your main concern about your teeth / bite?

______________________________

______________________________

***PLEASE COMPLETE OTHER SIDE**

**DR THERESIA R. SUDJALIM** **SPECIALIST ORTHODONTIST**

B.D.Sc. (Melb), D.C.D. (Melb), F.R.A.C.D.S.,
M.Orth R.C.S. (Edin), M.R.A.C.D.S. (Orth), A.O.B. (Cert)

LEVEL 1, 6 BOND ST, SOUTH YARRA VIC 3141 03 9131 1999 INFO@SYORTHO.COM.AU SYORTHO.COM.AU

## MEDICAL HISTORY (Please indicate any of the following)

- ☐ Diabetes
- ☐ Epilepsy
- ☐ Asthma
- ☐ Fainting
- ☐ Heart Condition
- ☐ Rheumatic Fever
- ☐ Endocrine Problems
- ☐ Cold Sores / Herpes
- ☐ Bone Disorder
- ☐ Excessive Bleeding
- ☐ HIV / AIDS
- ☐ Hepatitis
- ☐ Tonsils Removal
- ☐ Adenoid Removal

Any relevant details ____________________

Current medications ____________________

Allergies ____________________

## DENTAL HISTORY

- ☐ Thumb / Finger Sucking
- ☐ Grinding / Clenching
- ☐ Mouth Breathing
- ☐ Extra or Missing Teeth

Past injuries to the face / mouth ____________________

Have any family members had braces? ____________________

Has an Orthodontist been consulted previously ? ☐ Yes ☐ No

## SPORTS AND HOBBIES

____________________

____________________

## OTHER RELEVANT INFORMATION

____________________

____________________

If x-rays are required I,____________________ ( patient / parent / guardian ) consent to the taking of all radiographs.

**SIGNATURE** ____________________ **DATE** ____ / ____ / 2018

**THANK YOU.**

*This information will be traced in accordance with the organisations privacy policy.*

**DR THERESIA R. SUDJALIM** **SPECIALIST ORTHODONTIST**

B.D.Sc. (Melb), D.C.D. (Melb), F.R.A.C.D.S.,
M.Orth R.C.S. (Edin), M.R.A.C.D.S. (Orth), A.O.B. (Cert)

LEVEL 1, 6 BOND ST, SOUTH YARRA VIC 3141 03 9131 1999 INFO@SYORTHO.COM.AU SYORTHO.COM.AU