Turner Lim ORTHODONTISTS

Dr Fiona Turner BDS (Bristol, UK), MDS (Otago, NZ), FDSRCS(Eng).
Dr Donna Lim BDS (Otago), GradDipClinDent & DClinDent (Melbourne), MOrthRCS (Edin).

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PERSONAL INFORMATION

SURNAME:	FIRST NAME:
DATE OF BIRTH:	SEX: M / F (please circle one)
ADDRESS:	POSTCODE:
SUBURB:	TOWN:
HOME PHONE:	DAYTIME PHONE:
MOBILE:	EMAIL:

WHAT IS YOUR ETHNIC BACKGROUND? (This information is part of the criteria used in our digital imaging programme)

- ☐ NZ European/Pakeha
- ☐ NZ Maori
- ☐ South Pacific
- ☐ Chinese
- ☐ Indian
- ☐ Japanese
- ☐ Latin
- ☐ Korean
- ☐ African
- ☐ Other (please specify):

PARENTS (or caregiver): **Mr/Mrs/Ms** (please write full name)

PERSON RESPONSIBLE FOR PAYMENT: Mr/Mrs/Ms (please write full name)

MOBILE:	
ADDRESS:	
FAMILY DENTIST:	DOCTOR:
SCHOOL:	

REFERRED BY:

- ☐ Dentist
- ☐ School Dental
- ☐ Friend
- ☐ Family
- ☐ Yellow Pages
- ☐ Internet
- ☐ Other (please specify):

NO. OF CHILDREN IN FAMILY:

PREVIOUS ORTHODONTIC TREATMENT IN FAMILY:

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HEALTH HISTORY QUESTIONNAIRE

To assist us in providing the best possible care we need some essential information that is important for your welfare and treatment. We would be pleased if you could complete the following health questionnaire. If you are not certain about any of the questions please ask. **Please answer all questions.**

SURNAME:	FIRST NAME:	DATE OF BIRTH:

NAME & ADDRESS OF YOUR USUAL MEDICAL PRACTITIONER:

CIRCLE YES/NO AS APPLICABLE

Do you have any medical condition?	Yes/No	Are you being treated for any condition now?	Yes/No
Do you carry a special health card/bracelet?	Yes/No	**Females:** are you pregnant?	Yes/No

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Heart trouble/heart murmur	Yes/No	Rheumatic fever	Yes/No
Jaundice/Hepatitis	Yes/No	Diabetes	Yes/No
Fits/Epilepsy	Yes/No	Asthma	Yes/No
Dyspraxia/Autisim or Asperger's syndrome	Yes/No	Jaw fracture	Yes/No

Have you ever had any other serious illness	Yes/No	If YES, were you treated in hospital?	Yes/No
Are you taking any tablets, pills or medicine now or in the last six months?	Yes/No	Have you ever had a reaction to Penicillin, other antibiotics, any other tablets, capsules, medicines, injections?	Yes/No
Have you ever had a bleeding problem?	Yes/No	Have you ever had a bad reaction during dental treatment?	Yes/No
Have you injured a tooth?	Yes/No	Any history of osteoporosis or medication affecting bones?	Yes/No
Do you believe you may be at risk from any infections or any other diseases?	Yes/No	Have you ever had soreness, clicking or locking of your jaw joints?	Yes/No

Do you have any allergies? **Please list:**

Is there any other health matter your orthodontist should be aware of? **Please list:**

I understand that this information is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and only used to improve the quality of the service I receive. I further understand that payment is due on the day of my appointment.

SIGNATURE:	DATE: