Confidential Medical History & Consent Questionnaire

To obtain the best and safest treatment, your orthodontist needs to know of any problems which may affect your treatment.

Full Name: Date of Birth:

Address: Postcode:

Tel No: Mobile Tel No:

Email address: Sex: Age:

Your Doctor's (GP) name / address:

Your School's Name / address / telephone:

ARE YOU:

1. Attending or receiving treatment from a doctor? YES/NO
2. Taking any medicines, pills, inhalers, injections etc? YES/NO
   IF YES PLEASE STATE:

3. Allergic to any antibiotics, other medications or substances? YES/NO
   IF YES PLEASE STATE:

HAVE YOU:

1. Had arthritis/ rheumatic fever? YES/NO
2. Had heart murmur, hole in the heart or any heart problems? YES/NO
3. Had jaundice, liver disease or hepatitis B, C? YES/NO
4. Had Kidneys problem or disorders? YES/NO
5. Ever suffered from Epilepsy? YES/NO
6. Ever suffered from Diabetes? YES/NO
7. Had Asthma, Bronchitis or other chest problems? YES/NO
8. High/ Low Blood pressure? YES/NO
9. Had hay fever? YES/NO
10. Had joint replacement or any other implant ……..
11. Had anemia YES/NO
12. Blood borne disease (HIV/ Aids) YES/NO
13. Had blood refused by blood service YES/NO
14. Had history of excessive bleeding following dental extractions, cuts or bruise easily? YES/NO
15. Ever required antibiotics prior to dental treatment? YES/NO
16. Ever had any major operations in the past? YES/NO
17. For female patients, could you be pregnant? YES/NO

IS THERE ANY OTHER INFORMATION THAT YOU THINK YOUR ORTHODONTIST SHOULD KNOW?

Completed by: SELF / PARENT / GUARDIAN

Signature: …….

Date: ……

Giving Consent for Contacting Patient

1) **I confirm that my contact details are correct and I give consent to be contacted by Brace Place for the purpose of booking/rescheduling appointments, reminder of appointments and to discuss any aspect related to treatment by the following method. Please provide us with your details if they have changed.**

   - Phone call to home number or mobile number: ☐
   - Email: ☐
   - Text message: ☐

2) If I am unable to speak over the phone or receive a message or read any correspondence, I authorise Brace Place to leave a message on this telephone number:_____

3) **I give consent to Brace Place to cancel appointments, reschedule appointments, disclose appointment details and treatment information with a family member, friend, partner, or guardian (this applies to patients over 16 years old). Please specify the relationship (partner/spouse, parent/guardian, friend or carer) and provide the name(s) below**.

	First Contact	Second Contact	Third Contact
Full Name			
Relationship			
Phone Number			
Email address			

I consent to the treatment and to records being carried out by the orthodontist or an orthodontic therapist.

Consent for Referring Patient

I give consent to Brace Place to send a referral on my behalf / child's behalf to a specialist service or secondary care (hospital) when required.

Signature: ……..