for a smile
Geelong Orthodontics
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93 gellibrand st colac vic 3250

dr andrew wood
m d sc (melb) l d s (vic)
dr sergio bobbera
m d sc (melb) b sc (vic)
dr amanda leen
b d sc (hons) dcd (melb)

1300 462 722

Patient Information Form

info@goforasmile.com.au www.goforasmile.com.au 03 5222 6367

Patient Name: _____ D.O.B: _____ Sex:

Home Address: _____ Post Code: _____

Phone No: (H) _____ (W) _____ (M) _____

Parent/Responsible Party Email: _____

Patients School / University: _____

If patient is a minor, please give Parent(s) or Guardian's names: _____

Patient lives with: Parent(s) / Mother / Father / Self / Other: _____

Dentist: _____ Approximate date of last check up _____

Who may we thank for referring you to our practice? _____

Are you covered for Orthodontic Treatment by private health insurance? Yes / No

If so, name of insurer: _____

Parent/Responsible Party Information:

First Responsible Party Name: _____ Relationship: _____

Address: _____ Post Code: _____

Phone No: (H) _____ (W) _____ (M) _____

Email: _____

Second Responsible Party Name: _____ Relationship: _____

Address if different to above: _____ Post Code: _____

Phone No: (H) _____ (W) _____ (M) _____

Email: _____

Emergency Information:

Contact Person: _____ Relationship: _____

Phone No: (H) _____ (W) _____ (M) _____

General Information:

Has the patient ever had orthodontic treatment? Yes ☐ No ☐

If 'yes' with whom and what was the treatment? _____

Any medical conditions or allergies? _____

Please list any current medications _____

Has the patient had any problems with dental treatment? Yes ☐ No ☐

If 'yes', please describe:

Have any other family members had orthodontic treatment with us? Yes ☐ No ☐

If 'yes', what is the patient's name? _____

I understand that the above information will be kept strictly confidential.

Signature (Parent's signature if a minor) _____ Date _____