B. BERWICK.
ORTHODONTIC SPECIALISTS

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 (if applicable) _____

Home Address _____

Suburb _____ Postcode _____

Mailing Address (if different) _____

Suburb _____ Postcode _____

Email Address _____

Phone: Home _____ Phone: Work _____

Phone: Mobile _____ (mum/dad/guardian)

Occupation/ School _____

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 ALL PAGES

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)

DR THOMAS LO
SPECIALIST ORTHODONTIST
B.D.Sc.(Melb), D.C.D.(Melb), M.Orth R.C.S.
(Edin), M.R.A.C.D.S.(Orth), A.O.B.(Cert.)

2/31 CLYDE RD BERWICK VICTORIA 3806 AUSTRALIA 03 9212 0217 INFO@BERWICKORTHODONTICS.COM.AU

MEDICAL HISTORY (Please indicate any of the following)

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

Any relevant details _____

Current medications _____

Allergies _____

DENTAL HISTORY

☐ Thumb / Finger Sucking ☐ Grinding / Clenching ☐ Mouth Breathing

☐ Extra or Missing Teeth Past injuries to the face or mouth _____

Have any family members had braces? ☐ Yes ☐ No

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.

_____

_____

_____

HOW DID YOU FIND US

☐ ***DENTIST REFERRAL***	☐ ***FRIEND/FAMILY***	☐ ***WEBSITE***
☐ **GOOGLE**	☐ **STREET SIGNAGE**	☐ **SOCIAL**

PLEASE COMPLETE ALL PAGES

DR J. P. BRADLEY
SPECIALIST ORTHODONTIST
B.D.Sc.(UK), D.C.D.(Melb), A.O.B.(Cert.)

DR ANDREA PHATOUROS
SPECIALIST ORTHODONTIST
BDSc (WA), FRACDS, MDSc (Ortho)

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B. BERWICK.
ORTHODONTIC SPECIALISTS

PRIVACY POLICY

Our practice respects your right to privacy. We realise that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice and to whom this information might be disclosed.

You can otherwise rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice without your written consent. If you have any queries or your concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

The policy of our practice is to follow these procedures:

1. The information collected will be used for the purpose of providing treatment to you. Personal information such as your name, address and health insurance details will be used for the purpose of addressing account to you, as well as processing payments and writing to you about our services and any issues affecting your treatment.

2. We may disclose your health information to other health care professionals, or require it from them if, in our judgement, that it is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimised wherever possible.

3. We may also use parts of your health information for research purposes, in study groups or at seminars as this may provide benefits to other patients. Should that happen, your personal identity will not be disclosed without your consent to do so.

4. Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You may inspect or request copies of your records at any time or seek an explanation from the dentist. Statutory fees will apply in relation to the types of access you seek.

5. Any information posted to one of our social media sites will only be done so if verbal or written permission is gained.

6. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

PATIENT'S NAME _____

PARENT / GUARDIAN NAME _____

SIGNATURE _____ **DATE** ____ / ____ / _____

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