New patient registration

(Please return to: reception@mwdentalspecialists.com.au)

MIDWESTERN ALIGNER ORTHODONTICS

Patient details

Name: _____ Date of birth: / /

Phone: (H) _____ (M) _____ (W) _____

Email: _____

Address: _____

School / University / Employer: _____

If patient is a minor, name of parent(s)/guardian: _____

Medical and dental history

List medical conditions, medications or allergies: _____

Regular dentist: _____ Date of last dental check: / /

Any problems with dental treatment? _____

Any previous orthodontic treatment: Yes / No

Party responsible for account

Responsible party 1

Name: _____ Relationship to patient: _____

Email: _____ Employer/s: _____

Postal address: _____

Phone: (M) _____ (H) _____

Responsible party 2

Name: _____ Relationship to patient: _____

Email: _____ Employer/s: _____

Postal address: _____

Phone: (M) _____ (H) _____

General information

If the patient has private health insurance, please circle if covered for: General Dental Orthodontics

Name of health fund: _____

How did you hear about us? *(please circle)*

Recommended by dentist Internet search Friend Other: _____

Have any direct family members had orthodontic treatment by us? Yes / No

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

Acknowledgement by responsible party

- I have completed the above health and personal information to the best of my knowledge
- I am responsible for the account and am aware payment is due on day of consultation and on the day any treatment commences

Date: / / Name: _____ Signed: _____

Consent to photography

- I authorise Midwestern Aligner Orthodontics to take and securely store photographs of my / my child's teeth and face before, during and after treatment (an essential part of orthodontic treatment)
- These photographs may be used for purposes of dental records, education and research. This may include lectures, seminars and professional publications
- If photographs are used for the above purposes, patient name will be kept confidential
- No compensation will be given if these photographs are used for the above purposes
- Should I wish to revoke my permission I will inform of the change in writing

Date: / / Name: _____ Signed: _____