Gullotta Orthodontics

New Patient Info and Medical Form **Adult (18 and over)**

PATIENT DETAILS

Name: _____ DOB: _____

Address: _____

Phone (H): _____ (W): _____ Mob: _____

Email: _____

Occupation: _____

Dentist: _____ Health Fund (Dental): _____

How did you hear about us? _____

Details of any previous orthodontic treatment _____

Has anyone else in family been seen by Dr Gullotta. If yes, who _____

MEDICAL HISTORY

Do you wish to speak to Dr Gullotta privately regarding any health issues? _____

Are you taking, or have you taken medication for osteoporosis ? _____

Are antibiotics required **before** any dental treatment _____

Any allergies (including drug, gluten, nickel or latex) _____

List medication presently being taken _____

Are you pregnant ? _____

Please **tick only** if you have, or has ever had, any of the following :

☐ Asthma	☐ Prosthetic Implants	☐ Hormone therapy	☐ Blood Disorders
☐ Diabetes	☐ Epilepsy	☐ Speech problems	☐ Adenoids removed
☐ Rheumatic Fever	☐ Hepatitis	☐ Hearing problems	☐ Tonsils removed
☐ Heart murmur	☐ Liver disease	☐ Tuberculosis	☐ Facial trauma
☐ Heart disorders	☐ Kidney Disease	☐ Contact with HIV-AIDS	

Details / other information: _____

_____

_____

_____

PARENT OR GUARDIAN DETAILS (IF RESPONSIBLE FOR FEES)

Father's/Guardian's name: _____

Address: _____

Phone (H): _____ (W): _____ Mob: _____

Email: _____

Mother's/Guardian's name _____

Address: _____

Phone (H): _____ (W): _____ Mob: _____

Email: _____

I authorise Gullotta Orthodontics to provide relevant information to other health care professionals regarding patient care and treatment. I authorise Gullotta Orthodontics to provide financial information to health insurance agencies.

Signature: _____ **Name:** _____ **Date:** _____