Dr Ben Piller
BDS (Syd) MDSc (TAU)
Specialist Orthodontist
a: Westfield Tower 1 Level 16 Suite 1603
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1. Child's Information

Child's Name:_____
First Last
Birthdate: _____/_____/_____ Age _____
Home Address:_____

_____
Postcode
Mobile:_____
School:_____Year:_____

2. Parent 1 Information

❑ Mother ❑ Father ❑ Other_____
Name:_____
First Last
Phone (H):_____Phone (W):_____
Mobile:_____
Email:_____

3. Parent 2 Information

❑ Mother ❑ Father ❑ Other_____
Name:_____
First Last
Phone (H):_____Phone (W):_____
Mobile:_____
Email:_____

3. Dental History?

What is the main orthodontic concern?

_____

Who is your Dentist?

_____

Who may we thank for referring you?

_____

Is there a history of thumb sucking? ❑ Yes ❑ No

Is there a history of snoring? ❑ Yes ❑ No

4. Medical History

Please list any medication that the child is currently taking:

_____

_____

Has your child ever had any of the following medical conditions?

Excessive bleeding		❑ Yes ❑ No
Heart Murmur / condition		❑ Yes ❑ No
ADD/ADHD		❑ Yes ❑ No
Epilepsy		❑ Yes ❑ No
Anxiety		❑ Yes ❑ No
Depression		❑ Yes ❑ No
Diabetes		❑ Yes ❑ No
		❑ T1 ❑ T2
Rheumatic Fever		❑ Yes ❑ No
Hepatitis A, B or C		❑ Yes ❑ No
HIV / AIDS		❑ Yes ❑ No
Asthma		❑ Yes ❑ No
Sinus		❑ Yes ❑ No
Headaches		❑ Yes ❑ No
Adenoids removed		❑ Yes ❑ No
Tonsils removed		❑ Yes ❑ No
Ear problems		❑ Yes ❑ No
Allergies:	Latex	❑ Yes ❑ No
	Plastic	❑ Yes ❑ No
	Medication	❑ Yes ❑ No
	_____	
	Other	❑ Yes ❑ No
	_____	
Head, neck or spine injury?		❑ Yes ❑ No
Hospitalised recently		❑ Yes ❑ No

_____

I understand that the information given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my child's medical status.

_____
Signature of Parent / Guardian Date

_____
Name of Parent / Guardian