



Dr. Grant Hamilton-Ritchie
Prov. No: 2097794A
BDS Sc FRACDS MDS Sc MRACDS(Ortho)
SPECIALIST ORTHODONTIST
ABN: 14 111 798 906

13 South Street Ipswich Q 4305
Ph 3812 0865 Fx 3202 4698
ippyortho@westnet.com.au
www.ipswichorthodontics.com.au

WELCOME TO OUR ORTHODONTIC PRACTICE!!!!

We'd appreciate it if you could please complete this medical/dental questionnaire.

PATIENTS NAME: _____

FAMILY DENTIST/SCHOOL DENTAL CLINIC:

1. If your child is currently under the care of a medical practitioner or taking any medication at present,
Please discuss and list medications _____

2. Please tick if your child has had any of the following:

- | | |
|----------------------------------|---|
| MEDICAL | DENTAL |
| _____ A heart disorder | _____ Fluoride |
| _____ Bleeding disorder | _____ Breathe predominantly through the mouth |
| _____ Diabetes | _____ Sucked his/her thumb |
| _____ Asthma | _____ Stopped?? ___ When?? |
| _____ Rheumatic Fever | |
| _____ Tonsils/Adenoids removed | |
| | HAVE ANY PERMANENT OR BABY TEETH BEEN: |
| _____ Aids/ related disease | _____ Been extracted |
| _____ Hepatitis | _____ Had root treatment |
| _____ Thyroid Problem | _____ Been injured/chipped |
| _____ Attention Deficit Disorder | _____ Not appeared |

Any other illness/disability: _____

List any allergies: _____

- Has your child had any pain in the jaw or clicking?
If so please discuss: _____
- Has your child had any recent rapid growth? Yes: _____ No: _____
- Has your child ever had any speech therapy? Yes _____ No: _____
- Has your child inherited a family likeness in facial characteristic? If so please Explain: _____
- What is your main concern in seeking this appointment?

- To whom may we thank for referring you to our practice? _____

If your child subsequently develops any illness please keep us informed.

PERSON OR PERSONS RESPONSIBLE FOR THE ACCOUNT:

NAME: _____	NAME: _____
ADDRESS _____	ADDRESS: _____
_____	_____

Ph:..... Wk:..... Mobile.....

E-mail.....

THANK YOU FOR PROVIDING US WITH THIS INFORMATION.

SIGNATURE/RELATIONSHIP: _____ Date: _____