The Practice of Dr. Hashmat Popat and Associates

Specialist Orthodontists

Patient Information Form

Patient Name: _____ Preferred Name: _____
D.O.B. : _____ Gender: Male / Female / Other _____ Preferred Pronoun: He / She / They / Them
Home Address: _____
_____Postcode: _____
Phone No: (H) _____ (W) _____ (M) _____
Email Address: _____
Patient's School / University: _____
If patient is under 18 years, please give parent (s) or Guardians' names: _____
_____
Patient lives with: Parent(s) / Mother / Father / Self / Other _____
Family Dentist: _____
Who may we thank for referring you to our practice? _____
MEDICARE NUMBER: _____ REFERENCE: _____ EXPIRY: _____
Are you covered for Orthodontic Treatment by private health insurance? Yes / No
If so, name of Insurer: _____

Responsible Party Information (The Person who is responsible for paying for your treatment)

First Responsible Party Name: _____ Relationship: _____
Home Address (if not same as above): _____
_____Postcode: _____
Phone No: (H) _____ (W) _____ (M) _____

Second Responsible Party Name: _____ Relationship: _____
Home Address (if not same as above): _____
_____Postcode: _____
Phone No: (H) _____ (W) _____ (M) _____

Emergency Information:
Contact Person: _____ Relationship: _____
Phone No: (H) _____ (W) _____ (M) _____

General Information:
Has the patient had an orthodontic consultation before? Yes / No
If "yes", with whom: _____
Has the patient ever had orthodontic treatment? Yes / No
If "yes", with whom and what was the treatment? _____
_____
Any medical conditions or allergies? _____
Current medication list: _____
Have you had any problems with dental treatment? Yes / No
If "yes", please describe _____
Have any other family members had orthodontic treatment with us? Yes / No
If "yes", what is the patient's name? _____
I understand that the above information will be kept strictly confidential.

_____ _____
Signature (Parent's signature if under 18 years) **Date**

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