Confidential Medical History
Adult Questionnaire

MOG ORTHODONTICS

Welcome to MOG, please complete & return as soon as possible to enable us to prepare for your appointment.
If you would prefer to use our secure online form please go to MOGortho.com/Adult-MH

Patient Details

STAFF CHECK

First Name _____ Surname _____
(Mr/Mrs/Miss/Ms)

Residential Address _____

Suburb _____ Postcode _____

Phone Mobile _____ ☐ Mobile

Work _____

Email _____ ☐ Email

NOTE: This will be our primary form of contact

Date of Birth _____ ☐ D.O.B.

Gender Male / Female / Other

Medicare Number _____ ☐ Medicare

Individual Ref No _____ Expiry Date _____

Medical History

Please tick if YES

Have you ever suffered any of the following medical conditions:

Arthritis	☐	Difficulty swallowing	☐	Prolonged bleeding	☐	☐
Bone disorders	☐	Hepatitis B or C	☐	Are you a smoker?	☐	☐
Cleft Lip and/or Palate	☐	HIV/AIDS	☐	Sleep apnea	☐	☐
Diabetes	☐	Osteoporosis	☐			

Have you suffered a serious illness? ☐ _____
If yes please provide details

Are you under medical care, or taking medication? ☐ _____ ☐
If yes please provide details

Do you have a heart murmur or heart defect? ☐ _____ ☐
If yes please provide details

Have you ever taken bisphosphonate medication? ☐ _____ ☐
If yes please provide details

Are you allergic to any drugs, medication or latex? ☐ _____ ☐
If yes please provide details

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MOG ORTHODONTICS

Dental History

STAFF CHECK

When was your last dental examination? _____

Dentist & Practice name _____ ☐ Dentist

Dentist address _____

Do you have private health insurance with orthodontic cover? Yes ☐ No ☐

Note: Your answer will not affect your treatment options or total costs. We ask this solely to ensure we provide the correct item codes for your health fund's claims process, as these codes vary between insurance providers. ☐ P/health

If yes what is the name of your fund? _____

Please tick if YES

Have you ever had a deep filling or nerve removed from a tooth? ☐

Have you ever had a dental implant placed? ☐

Have you ever suffered any injuries to the face, jaw or teeth? ☐

Have you ever experienced any of the following jaw problems:

Clicking of the jaw? ☐ Frequent headaches? ☐

Pain in the jaw, ear or side of face? ☐ Difficulty chewing? ☐

Difficulty opening or closing your mouth? ☐

Orthodontic History

Has any other member of the family had orthodontic treatment? ☐ ☐ MOG Pt

Name(s) of family members who have had treatment with MOG (if applicable)

_____

Whom can we thank for your referral? _____ ☐ Referral

Have you had any previous orthodontic treatment? ☐

_____

If yes please provide details ☐ Ortho TX

_____

What are your reasons for seeking an orthodontic opinion? _____

_____

I have completed this entire Questionnaire to the best of my knowledge, and I understand that failure to make a full disclosure may place me at undue risk.

I agree to take responsibility for any fees incurred for my orthodontic treatment.

Patient Signature _____ Date _____