Align Orthodontics

PATIENT HISTORY

In order for this practice to provide the highest standard of care, it is requested you fill in this form carefully and thoroughly.

Title: Miss / Mrs/ Ms / Mst / Mr / Dr / Other) _____ Date of Birth _____

First Name/s _____ Surname _____

Home Address _____

Phone _____ Mobile _____ BH Phone _____

Email _____

Postal Address (if different from above) _____

Name of person responsible for fees _____

Address (if different from above) _____

Emergency Contact 1 _____ Relationship _____ Phone _____

Emergency Contact 2 _____ Relationship _____ Phone _____

Dentist _____ Phone _____

Address _____

Medical Doctor _____ Phone _____

Address _____

Do you have a health fund? ☐ Yes ☐ No If yes, please list fund _____

Who recommended our practice to you? _____

How did you find us ☐ Google ☐ Facebook ☐ Instagram ☐ Yellow Pages ☐ Other _____

Do any other family members attend our practice? _____

Do you have any hobbies or interest? _____

If applicable, what school do you attend? _____

If applicable, what year level? _____

PLEASE NOTE:
On future visits any changes to the above should be advised.

DR. BARBARA CARACH
175 Warrandyte Rd
Ringwood North
VIC 3134

Phone (03) 9876 1677
reception@alignorthodontics.com.au
www.alignorthodontics.com.au