NAME: Mr/Mrs/Miss/Ms/Dr ……

Home Address: ……

Email: …… Home Ph No: ……

Date of Birth: …… Mobile: ……

Referred by: …… Business Ph No: ……

Person responsible for payment: …… Relation: ……

Address (if different to above): ……

Do you have Private Health Extras cover? Y N Fund: ……

Membership No: …… Membership ID: 00 / 01 / 02 / 03 / 04 / 05 / 06

DENTAL HISTORY

Did you have x-rays with your previous dentist? Y N Are you satisfied with the appearance of your teeth? Y N

Have you visited your dentist regularly? Y N Have you any questions you would like answered? Y N

MEDICAL HISTORY

Doctor: …… Phone no: ……

The following conditions have important relevance to dental treatment – please put a tick against the condition(s) you think you currently suffer from or have had previously:

☐ Heart disorder	☐ Asthma	☐ Epilepsy	☐ Blood pressure (high/low)
☐ Fainting on injection	☐ Hepatitis	☐ Kidney problems	☐ Radiotherapy of head/neck
☐ Rheumatic fever	☐ Diabetes	☐ Arthritis	☐ Slow or complicated healing
☐ Thyroid problems	☐ Haemophilia		

Are you allergic to penicillin or to any other drugs? ……

Are you taking any anticoagulants? eg apixaban, clopidogrel, aspirin ……

Are you taking any medication regularly? ……

If YES, please list ……

For females – are you pregnant? …… If YES, how many weeks? ……

Please let us know if there are any other conditions or problems that may be relevant to your dental treatment:

……

……

ACCOUNTS

An account will be given to you at the completion of treatment. It is anticipated payment of the account will be made on the day of treatment. Hi-caps and credit card facilities are available.
If other payment arrangements need to be made, please discuss it with our practice manager prior to the commencement of treatment.

Signed: …… Date: ……