
**Thankyou for taking
the time to complete
this form.**

It's a great help for us.

Please return this to the receptionist
or nurse. We look forward to seeing
you shortly.

**Welcome
to**



We'd like to get to know you better ...

Thankyou for coming to our clinic. To ensure your comfort and most suitable dental care, we ask you to kindly complete the following questionnaire. Should you have any difficulties the staff are only too happy to help. All information will be treated as highly confidential.

SURNAME ^{MST} ^{MISS} ^{DR}
_{MR MRS MS} _____

FIRST NAMES _____ PREFERRED NAME _____

HOME ADDRESS _____

_____ POSTCODE _____

POSTAL ADDRESS (IF DIFFERENT FROM ABOVE) _____

_____ POSTCODE _____

TELEPHONE ☎ _____

MOBILE NO. _____ EMAIL _____

OCCUPATION _____

WORK ADDRESS _____ TELEPHONE ☎ _____

I WAS RECOMMENDED BY _____

MY DATE OF BIRTH IS _____

PERSON RESPONSIBLE FOR ACCOUNT (IF DIFFERENT FROM ABOVE)

NAME _____

ADDRESS _____

MY DENTAL INSURANCE FUND IS _____

MY FAMILY DOCTOR IS _____

HIS/HER ADDRESS IS _____

TELEPHONE ☎ _____

How are you?

Are you presently having treatment or taking medications? _____

Do you have (or have you ever had) any of the following?

Heart Disease	Yes	No
High Blood Pressure	Yes	No
Hepatitis	Yes	No
AIDS/HIV+ } Please discuss if } you are uncertain	Yes	No
Epilepsy	Yes	No
Diabetes	Yes	No
Rheumatic Fever	Yes	No
Asthma	Yes	No
Tuberculosis	Yes	No
Bleeding Problems	Yes	No
Allergies	Yes	No
Other Medical Conditions	Yes	No

→ If yes _____

Do you smoke? Yes No

Are you allergic to –

Penicillin? Yes No

Local Anaesthetic? Yes No

Ladies, are you pregnant? Yes No

Please sign here _____ Date _____