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

PARKSIDE DENTAL CLINIC

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 MR MISS MRS DR 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 } Please discuss if	Yes	No
AIDS/HIV+ } 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 _____