WELCOME TO ADAMS DENTAL WOULD YOU PLEASE FILL OUT THIS FORM

PERSONAL DETAILS

(Dr Mr Mrs Miss Ms) Surname:_____

Christian Names: _____ D.O.B:_____

Private Address:_____

Postal Address: _____

Occupation: _____

Home:_____ Business:_____ Mobile:_____

Email Address_____

Who is responsible for this account? _____

Who can we thank for recommending you to this practice?_____

Are you covered by private health cover? YES NO

If yes, which fund _____

Patient Number on your card next to your name 00 / 01 / 02 / 03 / 04 / 05 / 06

Reason for your visit today? (e.g. tooth ache, check up, clean, aesthetics)

_____

Are you interested in? TEETH WHITENING AMALGAM REMOVAL DENTAL IMPLANTS VENEERS

When did you last visit your dentist?_____

MEDICAL INFORMATION

Who is your medical practitioner? _____

Are you a smoker? (please circle) NO EX-SMOKER SOCIAL MODERATE HEAVY

Are you taking **ANY** medication or supplements? (Including but not limited to contraceptive pill, vitamins, dietary supplement, asprin, warfarin, fosamax)

_____

Please list **ANY** allergies to food or medicines? (e.g. Antibiotics, Codeine, Milk Products)

_____

Ladies, do you think you may be pregnant? (please circle) YES NO

Do you have **ANY** medical conditions?

☐ Asthma	☐ Rheumatic Fever	☐ Hepatitis A / B / C (Please Circle)
☐ Cancer	☐ Kidney Disease	☐ HIV
☐ Heart conditions	☐ Epilepsy	☐ Bleeding disorders
☐ Diabetes	☐ Reflux	☐ Anxiety / Depression
☐ Mental Disorders	☐ Prosthetic replacements	☐ Osteoporosis
☐ Stroke	☐ Thyroid conditions	☐ Musculoskeletal conditions
☐ Liver Complaints	☐ Arthritis	☐ Other
☐ Low Blood Pressure	☐ High Blood Pressure	

Please specify or add any relevant details:

_____

Signed:_____ Date:_____

Thank you for providing this important information which will remain part of your personal and confidential records.