brighter smile dental

Personal Details

Title (please circle): ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr

First Name: _____ Surname: _____

Preferred Name: _____ Date of Birth: _____/_____/_____

Address: _____

Postal Code: _____

Phone: (H) _____ (W) _____ Mobile: _____

Occupation: _____

Health Fund

Do you have Dental Insurance: ☐ Yes ☐ No

Name of the health Fund:_____

HAVE YOU EVER SUFFERED FROM or DO YOU SUFFER FROM:

	Yes	No		Yes	No
Osteoporosis	☐	☐	Prolonged Bleeding	☐	☐
Diabetes	☐	☐	Epilepsy/seizures	☐	☐
Heart Problems	☐	☐	Known Allergy to drugs, medicines, antiseptics.	☐	☐
High Blood Pressure	☐	☐	_____		
Hepatitis	☐	☐	Any other serious illnesses:	☐	☐
Asthma	☐	☐	_____		
Infective Endocarditis	☐	☐	Hospitalization in past 2 years	☐	☐
Rheumatic Fever	☐	☐	Reason: _____		
Are you a smoker	☐	☐			

ARE YOU AT PRESENT:

	Yes	No
Taking any medications (Please list)	☐	☐
_____		
Possibly pregnant.	☐	☐
Number of months _____		
Do you have any kind of prosthesis (besides dentures) ?	☐	☐
(eg. Prosthetic knees, joints, heart valve, etc.) _____		

When was your last dental visit? _____

Reason(s) for today's visit:

_____

How did you hear about us (please tick):

- ☐ I am a previous patient of this surgery
- ☐ Yellow pages
- ☐ Local Paper
- ☐ Mail Leaflets
- ☐ Saw the surgery's sign
- ☐ Recommended by a friend/relative
- ☐ Recommended by the Health Fund
- ☐ Others: _____

So we can link you on the computer as a family: Do we see any of your family members (same address)? Please name only one:_____

Signature: _____ Date: _____

Thank You for your time *and please note that this information will be treated with the strictest confidentiality.*