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.*

SUBMIT