



**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	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Known Allergy to drugs, medicines, antiseptics.	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Any other serious illnesses:	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Infective Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization in past 2 years	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Reason: _____		
Are you a smoker	<input type="checkbox"/>	<input type="checkbox"/>			

**ARE YOU AT PRESENT:**

Taking any medications (Please list)  Yes  No

\_\_\_\_\_

Possibly pregnant.  Yes  No

Number of months \_\_\_\_\_

Do you have any kind of prosthesis (besides dentures) ?  Yes  No

(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.***