EXQUISITE SMILES
... we create

Title (*Dr/ Mr/Mrs/Ms/Miss*):	Date of birth:	Gender:
First Name:	Last Name:	Preferred Name:
Occupation:	Home address:	
Nationality:	Ph (H):	Mob:
Email:		Preferred method of contact: TEL / SMS / EMAIL
Emergency contact person:	Relation:	Ph:

Are you currently with any health fund? If Yes, which one:

Do you require additional assistance? **N / Y** If Yes, how can we help:

Do you normally require antibiotic cover before dental treatment? **N / Y**

Have you had any abnormal reactions to local or general anaesthesia? **N / Y**

Do you smoke? **N / Y** Are you pregnant? (*Females only*) **N / Y** If Yes, weeks:

Have you ever been hospitalised in the last 12 months? **N / Y** If Yes, for:

Who is your medical practitioner? Ph:

Are you being treated by a doctor at present? **N / Y** If Yes, for:

Please list any current medications (including supplements):

Please list any drugs or medicines you are **allergic** to:

Please list any other known **allergies** (i.e. latex, food):

DO YOU HAVE NOW, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS?

	N	Y		N	Y		N	Y
Asthma			Excessive bleeding			Psychological or emotional problem		
Bronchitis or other lung diseases			Heart disorder			Radiation Therapy		
Blood pressure (high / low)			Heart surgery			Rheumatic fever		
Cardiac pacemaker			Hepatitis A, B, C			Steroid therapy		
Contact with bloodborne viruses			HIV			Stomach or digestive condition		
Diabetes			Kidney disease			Stroke		
Drug or alcohol dependency			Osteoporosis or other bone disease			Thyroid disease		
Epilepsy			Prosthetic implant eg artificial hip/knee			Tuberculosis		

Please list any other conditions not listed above:

Reason for your visit today (CONSULT / CLEAN / TOOTHACHE / any other):

Last dental visit: Reason:

Does dental treatment make you nervous? (NO / LITTLE / VERY):

Any concerns you have with your teeth or mouth?

HOW DID YOU HEAR ABOUT US? :

Recommended by (*please write name and number*):

I have completed the above to the best of my knowledge and understand that failure to make a full disclosure may place me at undue medical risk. I also understand that I am fully responsible for the financial aspect of my dental treatment.

Your / Guardian's signature: Date:

The information you provide is confidential and will be handled in accordance with our privacy policy.

OFFICE USE: Patient no: Reviewed by: Sign: Date: