PATIENT INFORMATION

Welcome to our Dental Surgery. Please take a few moments to answer these questions to assist us in providing you with the best and safest dental treatment possible.

Please note: All information provided will be treated with complete professional confidentiality

Title: Mr, Mrs, Miss, Ms, Mst, Dr	**Birth Date:**
Surname:	**Given Name:**
Address:	**Phone (Home):**
	Phone (Work):
Postcode:	**Phone (Mobile):**
Occupation:	**Email:**
Do you belong to a health fund which covers dental treatment? YES / NO **If yes, which health fund?**	

How did you discover our surgery?
What is the purpose of today's visit?
When was your last dental visit?

Do you suffer from any of the following?

Heart / Vascular Disorder:	**YES / NO**	**Please list your medications below:**
Blood Disorder:	**YES / NO**	
High Blood Pressure:	**YES / NO**	
Rheumatic Fever / Arthritis:	**YES / NO**	
Diabetes:	**YES / NO**	
Liver / Kidney Diseases:	**YES / NO**	
Asthma:	**YES / NO**	
Epilepsy / Faints:	**YES / NO**	
Allergies:	**YES / NO**	
Hepatitis / HIV:	**YES / NO**	
Radiotherapy / Chemotherapy:	**YES / NO**	
Osteoporosis:	**YES / NO**	
Other Health Concerns:		

The information declared above is true and correct to the best of my knowledge.

In the event of the account being in default and being referred to an external party for collection, the customer shall be liable for all resulting costs arising from the recovery, including commission (which would be payable if the accounts is paid in full) and legal costs (including legal demand costs).

Signature: _____ **Date**: _____/_____/_____