ROLEYSTONE DENTAL SURGERY

Welcome to our practice. Please answer these questions as completely as possible.

All information is kept confidential.

Mr/Mrs/Ms/Miss/Dr/other First Name: _____ Middle:_____

Surname:_____ Preferred Name: _____

D.O.B.: _____ Email: _____

Address: _____ Postcode: _____

Phone Home:_____ Phone Mobile: _____

Occupation:_____ Employer:_____

Whom may we thank for recommending you to our practice? _____

Which health fund do you belong to? _____

Where would you like reminders to be sent? (Please Tick) ☐ Email ☐ SMS ☐ Home Address

Emergency Contact Name: _____ Phone_____

Are you currently on any medication? If yes please list: _____

_____

Are you allergic to Penicillin, Codeine or any other antibiotics/medicines? _____

Do you have or have you ever had any of the following: **Please circle Yes or No.**

Rheumatic fever	Y/N	Heart problems	Y/N
High OR low blood pressure	Y/N	Osteoporosis	Y/N
Diabetes	Y/N	Hepatitis A, B or C	Y/N
Jaundice or liver disease	Y/N	Joint replacement surgery	Y/N
Epilepsy	Y/N	Thyroid disease	Y/N
Tuberculosis	Y/N	AIDS/HIV	Y/N
Females are you pregnant	Y/N	Do you smoke	Y/N

Signature: _____ **Date:** _____