ROLEYSTONE DENTAL SURGERY

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

All information is kept confidential.

Mr/Mrs/Ms/Miss/Master/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? _____

Please send regular recall reminders to: (please tick) Email ☐ SMS ☐ Home Address ☐

Emergency Contact Name (relationship) : _____ Phone _____

Parent/Guardian Name (if under 18):_____ Relationship:_____

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

_____

What is the name of your previous dental practice? _____

Would you like us to transfer your previous dental records? Y/N

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:** _____