

AQUAINTANCE FORM

In order to render dental treatment of a high standard, it is necessary to have the following information, which will be handled confidentially.

PLEASE FILL IN THIS FORM COMPLETELY.

Mr, Mrs, Ms, Miss, Mstr, etc

SURNAME: _____

FIRST NAME: _____ DATE OF BIRTH: ____/____/____

ADDRESS: _____

POSTCODE: _____

PHONE: (HM) _____ (WK) _____ (MOB) _____

PREFERRED CONTACT NUMBER: _____

OCCUPATION: _____

ARE YOU COVERED FOR DENTAL TREATMENT? YES / NO _____

FUND NAME: _____ Patient No: _____ Membership No: _____

Type of cover _____ Date Joined _____

WHO REFERRED YOU TO THIS PRACTICE? _____

<u>MEDICAL AND DENTAL HISTORY</u>	YES	NO
Have you ever had heart trouble or high blood pressure? <i>(please circle)</i>		
Have you ever had rheumatic fever, diabetes, hyperthyroidism, Asthma, glaucoma, nervous disorders, anaemia? <i>(please circle)</i>		
Have you ever had any serious illness?		
Have you ever been a patient in hospital during the past two years?		
Have you ever had a Blood Transfusion?		
Are you under current medical treatment?		
Are you taking any drugs or medicines?		
Have you any known allergies to drugs (especially penicillin) Medicines, antiseptics?		
Have you ever experienced prolonged bleeding?		
Have you ever had a difficult tooth extraction?		
WOMEN if <u>PREGNANT</u> , state how many months.		
Who is your family doctor?		
SIGNATURE _____ DATE _____		