Seaford Dental Clinic

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PATIENT HISTORY SHEET

Welcome to our practice.

For our confidential records, and to assist in determining, your treatment, please answer the following questions as accurately as possible.

Title: .....

Surname: ..... Given Names: .....

Date of birth: ..... Ph: ..... Mobile: .....

Home Address: ..... P/Code: .....

Email : .....

Postal Address (if different to above): .....

Name of Person responsible for Fees: .....

Address (if different to above): .....

Emergency Contact: ..... Ph: .....

Medical Doctor: .....

Address: ..... P/Code: ..... Ph: .....

How did you locate us: .....

Do you have Dental Insurance? NO YES Which Fund: .....

HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE INDICATE:

	NO	YES		NO	YES
Kidney	O	O	Hepatitis	O	O
Epilepsy	O	O	High Blood Pressure	O	O
Asthma	O	O	Heart Ailment	O	O
Diabetes	O	O	AIDS/HIV	O	O
Ladies are you pregnant?	O	O	Excessive Bleeding	O	O

- Do you smoke or have you previously been a smoker? .....
- I would like to discuss these questions in private with the dentist.....
- Do you have: an artificial hip, heart valve or other prosthetic implant.....
- Have you ever had problems with dental treatment?.....
- Are you presently under medical care or taking and medications or tablets?.....
- Please list any medications you are presently taking.....
- Please list any previous illness.....
- Do you have any allergies?.....
- Please list names of medicine or products you are allergic to.....

THANK YOU FOR YOUR ASSISTANCE.

I have completed this Questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place me at undue medical risk.

Signed: ..... **Date:** .....