

ACQUAINTANCE 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 the form completely.

NAME: (in full)

ADDRESS: Private Postcode

..... Phone

Business Phone

OCCUPATION - OR SCHOOL DATE OF BIRTH

ARE YOU COVERED FOR DENTAL TREATMENT?

If so to which Fund do you belong?

WHO REFERRED YOU TO THIS PRACTICE?

MEDICAL AND DENTAL HISTORY	YES	NO
Have you ever had heart trouble or high blood pressure?		
Have you ever had rheumatic fever, diabetes, hyperthyroidism, asthma, glaucoma, nervous disorders, anaemia, arthritis?		
Do you suffer from, or have any reason to suspect you may have Hepatitis, AIDS, or any other infectious disease?		
Have you ever had any other serious illness?		
Have you 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, iodine?		
Have you ever experienced prolonged bleeding?		
Have you ever had a difficult tooth extraction?		
Women if pregnant, state how many months.		
Who is your physician?		

SIGNATURE DATE