

PATIENT DETAILS

Samuel street dental practice ph 3398 1750



TITLE(eg Mr/Mrs)	
FIRST NAME	
PREFERRED NAME	
SURNAME	
DATE OF BIRTH	
ADDRESS	
POSTAL ADDRESS (if diff from above)	Post Code:
TELEPHONE	Hm: _____ Wk: _____ Mb: _____
OCCUPATION	
Private Dental Insurance	y/n If Yes which Fund?
Contact in case of Emergency	Name: _____ Ph No: _____
Are there any immediate family members currently patients of this practice?	y/n If yes, please indicate:
How did you come to know about this practice?	

MEDICAL DETAILS

Current Medical Practitioner Name:	_____
Phone No:	_____

Current Medications: _____

Please indicate if you have had any of the following?

Rheumatic Fever	y/n
Night sweats	y/n
Heart Murmur	y/n
Hepatitis A,B or C	y/n
Prolonged bleeding after injury or surgery	y/n
Diabetes Type 1/Type 11	y/n
Epilepsy	y/n
Heart Condition	y/n
HIV/Aids	y/n
Cancer Treatment	y/n
High/Low Blood Pressure	y/n
Any Blood Disorder	y/n
Any other illness or disability	y/n
Any joint Replacements	y/n
Are you pregnant?	y/n If yes how many months?
Do you smoke?	y/n
ALLERGIES- any food/drug etc	y/n If yes please indicate:

SIGNATURE:**DATE:**