City Smile dental centre

Welcome to City Smile Dental Centre.

In order to provide the best dental treatment of high standard, it's necessary to obtain the following information. All information obtained will be treated with complete professional confidentiality.

Full name:	Occupation:
Mr/Mrs/Ms:	Employer:
Address:	Phone Work:
Suburb/Post Code:	Phone Mobile:
Phone Home:	e-mail address:
Date of Birth:	Full Name:

Closest Relative:		Full Name:	Contact Phone:
Do you have Dental Insurance:		If yes what type?	
How did you discover us?	Yellow Pages	Reteral	Other (Please give details)
Purpose of today's visit:		Are you happy with your smile / teeth?	

Please answer the medical history questions with a ☑ if the answer is yes.

- Do you take drugs or prescribed medicine regularly? ☐
- Have you had a bad reaction to any treatment of medicine? ☐
- Have you had any serious health or mental problems? ☐
- Do you have a pacemaker? ☐
- Do you have any other implants? ☐
- Are you pregnant? ☐
- If yes, when is your due date? ☐
- Are you allergic to Penicillin ? ☐
- Are you allergic to Iodine? ☐
- Are you allergic to Sulphur? ☐
- Do you have any other allergies (please explain) ☐

Do you suffer from any of the following:

- Heart / Vascular disorder ☐
- Heart Murmur ☐
- Bleeding disorder / Bleeder ☐
- Blood Pressure Problems ☐
- Rheumatic Fever ☐
- Liver or Kidney Disease ☐
- Asthma ☐
- Epilepsy ☐
- Diabetes ☐
- Arthritis ☐
- Hepatitis A ☐ B ☐ C ☐ D ☐
- HIV / Aids ☐
- Do you have any infectious disorder not listed? ☐
- If yes please specify the disease ☐

This practise requires full payment on the day of treatment. Please note we do not accept cheques or dialer forms of payment.

How will you be paying: Cash: ☐ Credit Card ☐ Eftpos ☐ V/A ☐

Today's Date

Signature