Welcome to your Dental Office

"Helping *you* to keep *your* teeth for life"

First name:		Family Name:	
Home Address:		Home #	
Marital Status: Married/Single/Divorced/Widow		Work #	
Date of birth: D/M/Y __ __/__ __/__ __		Mobile #	
I.D./Passport:		Emergency contact #	
E-Mail :			
Who may we thank for referring you?			
MEDICAL HISTORY			
Allergies: Penicillin or other:			
Medication taking currently:			
Taken Bisphosphonates: past/present			
Do you suffer from:		Kidney Problems	Y / N
Heart Problems	Y / N	Hepatitis/Jaundice	Y / N
Anemia	Y / N	Asthma	Y / N
High/Low Blood pressure	Y / N	Osteoporosis	Y / N
Clotting problems	Y / N	Psychiatric Diseases	Y / N
Rheumatic Fever	Y / N	Do you smoke	Y / N
Diabetes	Y / N	Other:	
FOR WOMEN ONLY ♀			
Are you pregnant?	Y / N	If so what month	
Are you taking hormones / contraceptive pills?		Y / N	
DENTAL HEALTH ☺			
When was you last dental examination?			
What oral hygiene routine do you follow?			
Do you suffer from			
Gag Reflex	Y / N	Bad Mouth Odor	Y / N
Grinding/ Clenching	Y / N	Dental Surgery	Y / N
Is anything bothering you at the moment?			
Would you like your teeth to be whiter?			
Why did you leave your last dentist?			
Covid Vaccine Y / N / Recovered from Covid Y / N			

If you have any questions regarding the above form please do not hesitate to ask a member of our team or your doctor

SIGNATURE_____ **DATE**____/____/____