PATIENT RECORD FORM

Please note all your information is kept confidential

NEXGENDENTAL

Mr □ **Mrs** □ **Ms** □ **Miss** □ **Mstr** □ **Dr** □ **Other**_____

First Name:_____ Surname: _____ DOB:_____

Home Address: _____ Postcode: _____

Ph (Home):_____ Occupation: _____

Ph (Work): _____ Email: _____

Mobile: _____ Family Doctor: _____

Private Health Fund:_____ Membership number: _____

REASON FOR VISIT:

Check – Up □ Pain Relief □ Dental Cosmetics □ Botox □ Last visit to the dentist?_____

Does dental treatment make you nervous? No □ Slightly □ Moderately □ Extremely □

If you are an anxious patient, please advise staff and we will give you some further information.

MEDICAL HISTORY: Please tick which applies to you

□ Smoker □ Diabetes □ Epilepsy □ Cholesterol □ Depression □ Tuberculosis □ Asthma

□ High/Low blood pressure □ Hepatitis A /B / C □ Bleeding/Clotting Disorder □ Rheumatic Fever

□ Heart Problems (specify): _____ □ Pregnant:_____months □ Cancer (specify): _____
□ Allergies (specify) _____ □ Other:_____

□ Medications:_____

REFERRAL:

□ Family member/ friend:_____

□Internet □Radio □ Yellow Pages □ Newspaper □ Doctor:_____

SIGNATURE:_____ **DATE:**_____