Welcome to Look Good – Feel Good Dentistry.

To assist us in providing you with quality dental care, please complete this confidential form accurately.

Please print

Dr. Mr. Mrs. Ms. Miss. Mst.____
(First Name) (Initial) (Surname)

Address____

____P/code_________________

Telephone Nos. (H)_________________ (W)_________________ (Mob)____________________

Date of Birth _____/_____/______ Occupation (optional) __________________________

Referred by ____________________________

Person responsible for account _________________________________

MEDICAL HISTORY

Name of Medical Doctor ________________________________ Phone No.______________

Have you had or do you have:

Rheumatic Fever.... Yes / No Heart Condition…. Yes / No High Blood Pressure …. Yes / No

Excessive Bleeding…. Yes / No Stroke…. Yes / No Tuberculosis….Yes / No

Artificial Hip, Heart Valve, Pacemaker or Prosthetic Appliance.... Yes / No

Asthma…. Yes / No Diabetes….Yes / No Arthritis…. Yes / No Epilepsy.... Yes / No

Cancer…. Yes / No Radiation Treatment to Head or Neck….Yes / No

Hepatitis B or C… Yes / No HIV / AIDS….Yes / No

Nervous Conditions….Yes / No How is your general health?…. Good / Poor

Ladies, are you pregnant …. Yes / No / Maybe

Allergies to Medications, Drugs, Latex....Yes / No ……………………………………………….

PLEASE list any medicines, pills, tablets or drugs of any kind that you are taking -

Signed ____ Date _____/______/_________

PAYMENT AT TIME OF TREATMENT IS APPRECIATED