



**Thankyou for taking the  
time to complete this  
form.**

**It's a great help for us.**

Please return this to the receptionist  
or nurse. We look forward to seeing  
you shortly.



**Welcome  
to**



**DRS OPPES, SALTER,  
NAPOLI, ALLEN AND STAFF**





## We'd like to get to know you better ...

Thankyou for coming to our clinic. To ensure your comfort and most suitable dental care, we ask you to kindly complete the following questionnaire. Should you have any difficulties the staff are only too happy to help. All information will be treated as highly confidential.

SURNAME <sup>MST MR</sup> <sup>MISS MRS</sup> <sup>DR MS</sup> \_\_\_\_\_

FIRST NAMES \_\_\_\_\_ PREFERRED NAME \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

POSTCODE \_\_\_\_\_

POSTAL ADDRESS (IF DIFFERENT FROM ABOVE) \_\_\_\_\_

POSTCODE \_\_\_\_\_

TELEPHONE ☎ \_\_\_\_\_

MOBILE NO. \_\_\_\_\_ EMAIL \_\_\_\_\_

OCCUPATION \_\_\_\_\_

WORK ADDRESS \_\_\_\_\_ TELEPHONE ☎ \_\_\_\_\_

I WAS RECOMMENDED BY \_\_\_\_\_

MY DATE OF BIRTH IS \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT (IF DIFFERENT FROM ABOVE)

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

MY DENTAL INSURANCE FUND IS \_\_\_\_\_

MY FAMILY DOCTOR IS \_\_\_\_\_

HIS/HER ADDRESS IS \_\_\_\_\_

TELEPHONE ☎ \_\_\_\_\_



## How are you?

Are you presently having treatment or taking medications? \_\_\_\_\_  
\_\_\_\_\_

Do you have (or have you ever had) any of the following?

Heart Disease Yes No

High Blood Pressure Yes No

Hepatitis Yes No

AIDS/HIV+ } Please discuss if you are uncertain Yes No

Epilepsy Yes No

Diabetes Yes No

Rheumatic Fever Yes No

Asthma Yes No

Tuberculosis Yes No

Bleeding Problems Yes No

Allergies Yes No

Other Medical Conditions Yes No

→ If yes \_\_\_\_\_

Are you allergic to –

Penicillin? Yes No

Local Anaesthetic? Yes No

Ladies, are you pregnant? Yes No

Please sign here \_\_\_\_\_ Date \_\_\_\_\_

