GT DENTAL SPECIALIST

PATIENT INFORMATION FORM **Please write legibly & Tick the boxes as appropriate**

Visit Date: DD: MM: YY: State Of Origin

Phone Numbers: (1) (2)

Email Address:

Name: (Surname) (First) (Middle)

Home Address:

Occupation:

Sex: M☐ F☐ Marital Status: ☐Single: ☐Married: ☐Divorced: ☐Widow/Widower

Birth Date: DD: MM: YY:

Name of Next Of Kin:

Address of Next of Kin:

Relationship: Phone Number:

WHO REFERRED YOU TO OUR CLINIC

TRAVEL HISTORY

Have you traveled in the last 3 months?

Yes ☐ No ☐

Travel Details:
From:
To:

Special Notes (Clinic Use Only)

Single Card

Family Card

MEDICAL HISTORY TICK YES OR NO

Certain illness and drugs may require us to alter our treatment. We want to render the best possible dental care to you and your family, so please answer these questions to the best of your ability.

	Yes	No		Yes	No
Are you having pain or discomfort at this time?			Do you notice swelling in your Ankle during the day?		
Do you feel very nervous about having dental treatment?			Do you wake up at night to urinate frequently?		
Have you ever had a bad experience in a dental office			Are you thirsty most of the time		
Have you been admitted in a hospital during the past years?			Do you get dizzy when you sit up quickly from sleep?		
Are you currently taking any medicines or drugs?			Have you lost or gained more than 5kg in the past year/		
If yes, please list them...			Have you ever woken up short of breath		
Are you allergic or made sick by any drugs or medications?			Are you on a special diet?		
If yes, please list them...					
Have you ever had any excessive bleeding requiring special treatment?					
When you walk up the stairs or take, a walk, do you ever have to stop because of pain?					

Do you, or have you ever had any of the following:

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease or Attack			Emphysema			Cough			Cancer			Angina Pectoris		
High Blood Pressure			Alcoholism			Tuberculosis			Epilepsy/Seizures			Fainting/Dizzy Spells		
Heart Mumur			HIV/AIDS Infections			Asthma			Sinus Trouble			Chemotherapy		
Heart Surgery			Allergies			Glaucoma			Ulcers			Mental/Psychiatric		
Rheumatic Fever			Cold Sores (Herpes)			Anaemia			Arthritis			Blood Transfusion		
Stroke			Diabetes			Liver Disease			Yellow Jaundice			Genital Herpes		
Cogenital Heart Lesions			Veneral Disease			Kidney Disease			Heart Pacemaker			Respiratory		
Hepatitis A (Infections)			Bruise Easily			Artificial Heart Value			Head/Neck Injury			Radiotherapy		
Hepatitis B			Drug Addiction			Thyroid Disease			Haemophilia			Pain in Jaw Joints		
Artificial Joint			Sickle Cell Disease											

Women

	Yes	No
Are you Pregnant?		
Are you practicing Birth Control		

Name of your medical Doctor Phone No of your Doctor:

Declaration

To the best of my knowledge, all preceeding answers are TRUE and CORRECT. If I ever have any change in my health status, or if my medicines change, I will inform the Dentist at my next visit.

Date..... Signature.....

Authorisation

I hereby grant complete authority to the Dentist to administer any treatment, anaesthetics, X Rays and Dental procedures that may be necessary or advisable in the diagnosis and treatment of my Dental Condition.

INFORMED CONSENT REVIEW DATES

SIGNATURE OF PARENTS OR GUARDIANS