SYNERGY DENTAL

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you on maintaining your dental health.

PATIENT INFORMATION

PATIENT NAME: _____ | _____

First Name Middle Surname Male/Female

DATE OF BIRTH: __ __ / __ __ / __ __ OCCUPATION: OR SCHOOL YOUR CHILD ATTENDS _____

HOME PHONE: _____ MOBILE: _____

ADDRESS: _____

E-MAIL: _____

Emergency Contact Name: _____ Home Phone: _____

Mobile phone: _____ Work Phone: _____

Are you covered by any dental insurance: _____ Provider: _____

Doctors Name: _____

Medical Practice Name: _____

DENTAL INFORMATION

How can we help you today? _____

_____

Are you in dental discomfort today? _____

Name of last Dentist/Practice: _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ____ YES _____ NO

CONVENIENCE

Bathrooms are located in the stairwell and have a pin number on the door.

MALE: PIN 124 (On Level 7)

FEMALE: PIN 189 (On Level 6)

Wheelchair access is available on request.

In the event of an emergency please follow the instructions of a Health and Safety officer.

CLINICIAN INITIAL

CONFIDENTIAL MEDICAL HISTORY

PLEASE READ CAREFULLY MARK BOXES WITH **X** WHERE RELEVANT

HEART	Rheumatic Fever		Heart Murmur		High/Low blood pressure	
	Angina		Heart surgery		Stroke	
	Pacemaker fitted		Thromosis		Other heart conditions	
BLOOD	Hepatitis A,B,C or D		Anaemia		H.I.V./AIDS	
	Abnormal blood test		Sickle cell		Other blood conditions	
	Transfusion service/refused blood		Haemophilia			
ALLERGY	Penicillin allergy		Latex allergy		Local anaesthetic allergy	
	Hayfever allergy		Medicines allergy		General anaesthetic allergy	
	Anti tetanus serum allergy		Plants allergy		Aspirin allergy	
	Eczema allergy		Food allergy		Other allergy conditions	
CHEST	Bronchitis		Emphysema		Asthmatic	
	Cystic Fibrosis		Pneumonia		Tuberculosis	
	Pleurisy		Chest Surgery		Other chest conditions	
OTHER	Cancer/Radiotherapy		Kidney disease		Epilepsy	
	Artificial Joint		Fainting / blackouts		Pregnant / possibly pregnant	
	Bone or joint disease		Past infectious disease		Liver disease	
	Antibiotic cover required		Depressive illness		Diabetes	
	Bruising or persistent bleeding		Treatment requiring hospital		Acid reflux or eating disorder	
	Currently under treatment		Hearing/Sight impaired		Do not recline	
	Cold Sores		Warning card		Steroids within 2 years	
	Severe headaches/Migrains		Nervous problems		Hiatus Hernia	
DETAILS:						
DETAILS:						

LIST MEDICATIONS

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to determine the appropriate management of my treatment. If there is any change in my medical status, I will inform the dentist.
I authorise the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance.

SIGNED BY CLIENT/GUARDIAN

DATE: __ __ / __ __ / __ __