PEAK
DENTAL CARE

Title: MR MRS DR MISS MS

First name: _____ Surname: _____

Address: _____

_____

DOB: _____/____/_____

Phone numbers: Home: _____ Mobile: _____

Email: _____

Emergency Contact

Name: _____ Contact number: _____

Do you have a Dental Health Fund? YES ☐ NO ☐

Name of Fund: _____

We remind our patients of their appointments. Please circle your preferred means of contact:

SMS to mobile ☐ Home phone ☐ Mobile ☐

How did you hear about us?

☐ Search engine ☐ Word of mouth Other _____

☐ Website ☐ Advertising

☐ Signage ☐ Facebook

Please tick any dental concerns you have:

☐ Toothache ☐ Missing teeth ☐ Pain in face or jaw joints

☐ Sensitive teeth ☐ Unsatisfactory denture ☐ Difficulty chewing

☐ Bleeding gums ☐ Rapidly decaying teeth ☐ Discoloured teeth

☐ Loose teeth ☐ Lost filling/cavity ☐ Bad appearance of teeth

☐ Bad breath ☐ Grinding/clenching teeth

☐ Dry mouth ☐ Worn/broken teeth

Medical History

Do you have any allergies? YES/NO _____

What medications are you currently taking?

_____

_____

Please tick if you have any of the following:

- ☐ Heart problems
- ☐ Pacemaker
- ☐ Heart valve replacement
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Stroke
- ☐ Diabetes
- ☐ Rheumatic fever
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Thyroid problems
- ☐ Asthma
- ☐ Epilepsy
- ☐ Sleep apnoea
- ☐ Stomach or digestive condition/Reflux
- ☐ Bleeding problems
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Cancer
- ☐ Infectious diseases e.g. HIV, hepatitis, TB

Are you a smoker? YES ☐ NO ☐

Are you pregnant? YES ☐ NO ☐

Who is your General Practitioner? _____

Phone number: _____

Terms of acceptance:

- I have accurately completed the above questionnaire to the best of my knowledge.
- All information is considered confidential and is necessary to ensure that the best possible treatment can be provided.
- I hereby give my authority for any treatment agreed upon by me, to be carried out by the dentists and their staff, and I assume full financial responsibility for said treatment.
- I understand that any expenses, costs or disbursements incurred by Family Dental Practice in recovering outstanding fees, including debt collection fees and solicitor costs, shall be paid by the responsible party above.
- I authorise for records to be forwarded to dental specialists that may be involved in my treatment.

Patient signature: _____ Date: _____

Dentist signature: _____ Date: _____