ACQUAINTANCE FORM

Name: Dr | Mr | Mrs | Miss | Ms | Other .....

Address: .....

..... Postcode: .....

Phone Number Mb: ..... Hm: .....

DOB ..... Occupation .....

Are you covered by a health fund .....

How did you hear about this practice .....

Have you any concerns with your teeth / mouth .....

MEDICAL HISTORY

Are you receiving any medical tx at present? .....

Have you had any long standing illness? .....

Please indicate if you have any of the following:

Any heart complaint / treatment?	Y☐ N☐	Any nervous system disorder	Y☐ N☐
Rheumatic fever / heart valve surgery	Y☐ N☐	Asthma / lung condition	Y☐ N☐
High or low blood pressure	Y☐ N☐	Joint replacement surgery	Y☐ N☐
Anti-coagulant therapy	Y☐ N☐	Transplant organ / bone marrow	Y☐ N☐
Epilepsy	Y☐ N☐	Having Radiation / chemo therapy	Y☐ N☐
Diabetes	Y☐ N☐	Having treatment for any form of cancer	Y☐ N☐
HIV	Y☐ N☐	Pregnant (how many weeks)	Y☐ N☐
Hepatitis, Jaundice or Liver disease	Y☐ N☐	Other	Y☐ N☐
Tuberculosis	Y☐ N☐		
Arthritis	Y☐ N☐		

Allergies .....

Current medications .....

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Sign: ..... Date: .....