beyond. DENTAL

Personal Details

Full Name | DOB

Email | Occupation

Contact Number | School

Address

How did you find us? Friends/Family

Who referred you to us? (we send them a small gift)

Would you like to register additional family members with us while you are here?

Drink Preference Water

Medical History

GP Practice and Doctor Name

Pharmacy

Emergency Contact Name and Number

Current Medications

Current Supplements

Dietary Habits

Drug Allergies

Smoking History

Alcohol/Drug Use

Continued over page

Please tick box if the following applies and provide appropriate details

- ☐ Anaemia
- ☐ Angina
- ☐ Antibiotic Cover
- ☐ Artificial Joints
- ☐ Artificial Heart Valves
- ☐ Bleeding Issues
- ☐ Breastfeeding
- ☐ Breathing/Chest Issues
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting/Dizziness
- ☐ Heart Attack
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ High cholesterol
- ☐ Hospitalisation/Major Surgery
- ☐ Kidney Issues
- ☐ Liver Issues
- ☐ Pacemaker
- ☐ Pregnant
- ☐ Reflux
- ☐ Rheumatic Fever
- ☐ Sleep Issues (snoring, grinding, sleep apnoea)
- ☐ Stomach Issues
- ☐ Stroke
- ☐ Other

Details

Dental History

Your previous dentist

Your most recent dental visit

What can we help you with?

What are your oral health goals?

Are you happy with your smile?