WELCOME TO BEAUTIFUL SMILE DENTAL us to look after your dental health

Title Mr/Mrs/Ms /Miss/Mst. (Please circle) Home Address: OCCUPATION: Employer's Name. Telephone No: Home. Work. Mobile. Email. How did you hear about our practice (eg. Friend or relative referral, yellow pages health fund) Do you have private health insurance for dental treatment? YES/NO If yes, Name of fund. HAVE YOU HAD ANY OF THE FOLLOWING? (please circle YES or NO) Diabetes YES/NO Heart Trouble YES/NO Heart Walve Ailments Glaucoma YES/NO Heart Valve Ailments YES/NO Heart Walve Ailments YES/NO Heart Walve Ailments YES/NO Reumatic fever YES/NO Cancer YES/NO Reumatic fever YES/NO Chemotherapy YES/NO Gastric reflux YES/NO Depression YES/NO Radiotherapy YES/NO Radiotherapy YES/NO Robert Problems YES/NO Robert Problems YES/NO Robert Problems YES/NO Robert Problems YES/NO Osteoporosis YES/NO Do you smoke YES/NO Do you smoke YES/NO How many per day My Medical practioner's name is Do you have any allergies? Please list Are you taking any drugs. medicines. or tablets YES/NO Please List Pemale Patients Are you pregnant? Due date? WHICH OF THE FOLLOWING ARE YOUR DENTAL CONCERNS? (please circle YES or NO) Discoloured teeth YES/NO Missing teeth YES/NO Prequent Headaches YES/NO Lost/Broken fillings YES/NO Lost/Broken fillings YES/NO Worn/Broken Teeth YES/NO Lost/Broken fillings YES/NO YES/NO Lost/Broken fillings YES/NO YES/NO Lost/Broken fillings YES/NO YES/NO Lost/Broken fillings YES/NO YES/NO YES/NO Replacement of amalgam	Surname:	First Name		
Home Address: OCCUPATION: Telephone No: Home	Title Mr/Mrs/Ms /Miss/Mst. (Please circle	e) Date of Birth:		
CCCPATION: Employer's Name. Home	Home Address:			
Home	OCCUPATION:	Employer's Name	e	
Mobile	Telephone No:	Home		
Email How did you hear about our practice (eg. Friend or relative referral, yellow pages health fund) Do you have private health insurance for dental treatment? YES/NO If yes, Name of fund HAVE YOU HAD ANY OF THE FOLLOWING? (please circle YES or NO) Diabetes				
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Do you have private health insurance for dental treatment? If yes, Name of fund	How did you hear about our practice (eg.	Friend or relative referra	al, yellow pages health fund)	
If yes, Name of fund	Do you have private health insurance for o	dental treatment?		
Diabetes	If yes, Name of fund			
Asthma	HAVE YOU HAD ANY OF THE FOLI	LOWING? (please circ	cle YES or NO)	••••••
Asthma	Diabetes	YES/NO	Heart Trouble	VES/NO
Thyroid Problems YES/NO Heart Valve Ailments YES/NO Glaucoma YES/NO High Blood Pressure YES/NO Rheumatic fever YES/NO Kidney diseases YES/NO Hepatitis YES/NO Kidney diseases YES/NO Hepatitis YES/NO Gastric reflux YES/NO Depression YES/NO Radiotherapy YES/NO Radiotherapy YES/NO Bepilepsy YES/NO Tuberculosis YES/NO Bepilepsy YES/NO Stomach/Bowel Problems YES/NO Osteoporosis YES/NO Do you smoke YES/NO How many per day				
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Do you have any allergies? Please list				
Are you taking any drugs, medicines, or tablets YES/NO Please List Female Patients Are you pregnant?	My Medical practioner's name is			
Are you taking any drugs, medicines, or tablets YES/NO Please List Female Patients Are you pregnant?	Do you have any allergies? Please list			
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Worn/Broken Teeth YES/NO Lost/Broken fillings YES/NO Replacement of amalgam (Silver) fillings YES/NO How long has it been since you last visited a dentist	Sensitivity to Hot/Cold	YES/NO	Pain /Infection	YES/NO
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How long has it been since you last visited a dentist Person responsible for account		YES/NO	Lost/Broken fillings	YES/NO
How long has it been since you last visited a dentist Person responsible for account	Toothache	YES/NO	Replacement of amalgam	
Person responsible for account				YES/NO
	How long has it been since you last visited	a dentist		
I understand that payment of the account is my responsibility and that the health fund (if any) will and	Person responsible for account			
I understand that payment of the account is my responsibility and that the health fund (if any) will and	Landania			
full amount. I undertake to pay any further expenses incurred resulting from my default on overdue account	I understand that payment of the account is	my responsibility and t	hat the health fund (if any) wil	l not cover t