



## PERSONAL INFORMATION

First Name :		Mr : <input type="radio"/>	Mrs : <input type="radio"/>	Ms : <input type="radio"/>	Miss : <input type="radio"/>
Last Name :					
Date of Birth :		Gender M : <input type="radio"/> F : <input type="radio"/>	Country of residence :		
Phone :		Mobile :	Fax :		
Address :					
Email address :					

## MEDICAL CONDITIONS (are you suffering from any of the following conditions, please indicate YES or NO)

Diabetes or blood sugar irregularities	Y <input type="radio"/>	N <input type="radio"/>
Cardiovascular/Heart problems	Y <input type="radio"/>	N <input type="radio"/>
High blood pressure	Y <input type="radio"/>	N <input type="radio"/>
Blood disorders/Blood clotting	Y <input type="radio"/>	N <input type="radio"/>
HIV or AIDS	Y <input type="radio"/>	N <input type="radio"/>
If you have answered YES to any of the above, please specify :		
Do you have or have you had any other medical conditions not mentioned above? If yes, please specify :	Y <input type="radio"/>	N <input type="radio"/>
Have you had any previous dental procedures that you were not satisfied with? If yes, please specify :	Y <input type="radio"/>	N <input type="radio"/>
Did you have any complications with this previous dental work?	Y <input type="radio"/>	N <input type="radio"/>

## WOMEN

Do you take birth control pills, hormone replacement medication or wear a hormone patch?	Y <input type="radio"/>	N <input type="radio"/>
Are you pregnant?	Y <input type="radio"/>	N <input type="radio"/>



## MEDICAL HISTORY

Have you been hospitalised, had surgery or received medical care within the last 12 months? If yes, when and what for?	Y <input type="radio"/> N <input type="radio"/>	N <input type="radio"/>
Do you have any allergies to food, medication, herbs etc.? If yes, please specify :	Y <input type="radio"/> N <input type="radio"/>	N <input type="radio"/>
Do you take regular anticoagulants such as Coumadin, Heparin, Warfarin or Aspirin? If yes, when was your last dose?	Y <input type="radio"/> N <input type="radio"/>	N <input type="radio"/>
Do you smoke? If yes, how many per day?	Y <input type="radio"/> N <input type="radio"/>	N <input type="radio"/>
Do you drink alcohol? If yes, how many drinks (on average) per day?	Y <input type="radio"/> N <input type="radio"/>	N <input type="radio"/>
Do you have or have you had any other medical history that your dentist should be aware of? If YES, please specify:	Y <input type="radio"/> N <input type="radio"/>	N <input type="radio"/>

## STEP 2 : DENTAL CONCERNS

TOP

BOTTOM

molars

premolars

canines

incisors

canines

premolars

molars

Please circle problematic teeth on the picture and make any remark here.

What dental procedures are you requesting?

## PHOTOGRAPHS REQUIRED FOR ASSESSMENT

Please provide photos of your teeth.