CLINICAL DENTAL TECHNICIAN PATIENT REGISTRATION AND HEALTH QUESTIONNAIRE

REGISTRATION

Title : Dr, Mr, Mrs, Miss, Ms

Gender . . M . . F (Please circle one)

Surname . . . .

First Name . . . .

Address . . . .

. . . .

Date of Birth . . . . / . . . / . . . .

Home Phone . . . .

Occupation . . . .

Work Phone . . . .

CONFIDENTIAL HEALTH QUESTIONNAIRE

Please answer all questions : if you require assistance to fill in the form please ask the technician.

1. Who is your General Medical Practitioner? . . . .

2. Who is your General Dental Practitioner? . . . .

3. Are you under treatment for a medical condition? . . . . Yes / No . . . .

   If yes, what is the condition? . . . .

4. Have you ever had a serious medical condition in the past? Yes / No. . . . .

   If yes, what is the condition? . . . .

5. Do you carry a Medical Alert Bracelet or Card? Yes / No . . . .

6. Are you sensitive to any medicines or other things (such as rubber type materials, detergents or disinfectants)? Has your skin reacted in any way?

7 Have you ever had any of the following? (please circle)

Heart problems	Epilepsy, fits
Rheumatic Fever	Asthma
Tuberculosis	Bleeding problems
Hepatitis or jaundice	HIV/Aids
Diabetes	Other

8. What medicines have you taken over the past year?

Patient's Signature . . . .

Date . . . / . . . / . . . .