Welcome to 'Bli Bli Smiles'

Title: Mr. Mrs. Ms. Miss. Other **Surname**:_____

First Name:_____ **Date of Birth**:___/___/___ Age in Years:____

Phone: (H)_____(W)_____(M)_____

Address:_____

_____

Health Fund:_____ Card No:_____ Series:_____

We like to confirm your appointments. How can we do this for you?
□ Phone on H / W / M □ None (I always remember)

How did you hear about us? □ Letterbox drop □ Yellow Pages small □ Internet
□ Website □ Sign □ Other:_____ (Please give name)

How can we help you? □ Total dental care / improve my smile
□ Pain relief only □ Pain relief and limited treatment

Would you like to receive regular preventative-care? □Yes □No

I am concerned about: □ tooth colour □ chipped tooth □ my gums □ sore jaw □ grinding of teeth □ food getting stuck □ bad breath
□ other:_____

MEDICAL: Do you have any relevant conditions? (Please circle)

High blood pressure	Bleeding disorders	Pregnancy
Low blood pressure	Rheumatic fever	Diabetes
Heart disease	Arthritis	Kidney/liver disease
Cardiac pacemaker	Bone disorders	Asthma
Disorders	Epilepsy	Transplants
Hepatitis	HIV	

Other: _____

Operations:_____

ALLERGIES:_____

Medications: Yes No If yes, please turn over to list medications

Signature:_____ **Date**:_____