New Periodontal Patient Registration

Please complete the following as accurately as possible. All information is treated in the strictest confidence.

If you have any difficulty in completing this, please ask for help.

First Name_________________. Surname(Mr/Mrs/Miss/Ms/Dr) ________________________________

Address ____

____

____

Postcode_________________ Home Tel No.: ____________________________________

Date of Birth:___/___/____ Work Tel No.: ____________________________________

Email : ________________________ Mobile Tel No.: ____________________________________

Are you receiving any medical treatment at present ? *(If so please give brief details)*

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Are you taking any medicines, tablets, injections or using any creams etc ? *(If so, please state which)*

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Are you allergic to Penicillin or any other drug or substance ? *(If so, please state which)*

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Have you ever had ? (Please delete as appropriate and give details) **:**

Rheumatic fever, chorea, heart defect, heart murmur or heart valve replacement ? (Yes/No)

Angina / Heart Attack ? (Yes/No)

Raised Blood Pressure ? (Yes/No)

Chest trouble, Asthma or T.B. ? (Yes/No)

Do you smoke ? (Yes/No) If yes, about how many per day ?________

Hepatitis, yellow jaundice, diabetes or epilepsy ? (Yes/No)

Any other operations or illnesses treated in hospital ? (Yes/No)

Have you had prolonged bleeding following extractions or surgery ? (Yes/No)

Have you any health matter that has not been mentioned or that you wish to discuss **in confidence ?**

Signed:____________________________________. Date: ______________________.