ACQUAINTANCE FORM

Dr / Mr / Ms / Mrs / Mdm / Miss / Master

Family Name: _____ Given Name: _____

Gender: Male / Female Nationality: _____

Home Phone: _____ Mobile: _____ Office: _____

Email: _____

Address: _____

_____ Postal Code: _____

Date of Birth: _____ NRIC/Passport: _____

Occupation: _____ Referred by: _____

Language Spoken: English / Chinese / Malay / Other:

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MEDICAL HISTORY

Have you been hospitalized before? If yes, please state when, why and which hospital. Yes / No

_____

Are you allergic to any medications? If yes, what are you allergic to? Yes / No

_____

Are you taking any medications? If yes, please specify. Yes / No

_____

Please circle if you have or have had any of the following conditions:

Asthma	Blood Transfusion	Diabetes	Epilepsy
Gastric Problem	Heart Murmur	Heart Problems	Hepatitis A/B
Herpes	High Blood Pressure	High Cholesterol	Jaundice
Kidney Trouble	Liver Disease	Mitral Valve Prolapse	Pacemaker
Prolonged Bleeding	Rheumatic Fever	Thyroid Disease	AIDS

Do you have any disease, condition or problem not listed above?

_____

Do you smoke? Yes / No If yes, how much? _____

Female: Are you pregnant? Yes / No If yes, when are you due? _____

I declare that the above information is true and correct to the best of my knowledge. Should there be any changes to my medical condition or medication, I will inform the dental clinic at the earliest opportunity.

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Signature of (Patient/Parent/Legal Guardian) Date

SHENTON DENTAL GROUP
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