RICHMOND
Dental Care

FULL NAME ....

Mr/Mrs/Miss/other...Date Of Birth..

ADDRESS...POSTCODE...............................

HOME TELEPHONE NUMBER.................................MOBILE ....

WORK .... E-MAIL ADDRESS..

ARE YOU A MEMBER OF WESTFIELD?..

PLEASE LIST ANY MEDICAL CONDITIONS OR ANY REASON FOR BEING TREATED/INVESTIGATED BY THE DOCTOR/HOSPITAL

....

ARE YOU PREGNANT..

PLEASE LIST IF YOU HAVE ANY ALLERGIES...

DO YOU TAKE MEDICATIONS FOR OSTEOPOROSIS OR WARFARIN ....

PLEASE LIST ALL MEDICATIONS CURRENTLY BEING TAKEN

1)... 2)..

3)... 4)..

5)... 6)..

7)..8)..

HOW MANY OF UNITS OF ALCOHOL DO YOU DRINK PER WEEK (1 UNIT IS HALF A PINT OF LAGER, SINGLE MEASURE OF SPIRIT OR SMALL GLASS OF WINE) ....

DO YOU SMOKE? YES/NO IF YES HOW MANY DAILY ....

PATIENT SIGNATURE..DATE..

DENTIST SIGNATURE ....DATE..

PLEASE ENSURE YOU HAVE FULLY COMPLETED THIS FORM BEFORE ENTERING THE SURGERY

Mr. Yusuf Lone & Associates
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