



Surname First Name(s)
Title (Mr/Mrs/Other)..... Date of Birth
Address Postcode
Telephone (inc. code) Mobile
Email

Do you now suffer, or have you ever suffered from, any of the following conditions?

- Heart problems Yes [] No [] Lung problems (including asthma) Yes [] No []
High blood pressure Yes [] No [] Low blood pressure Yes [] No []
Seizures/epilepsy Yes [] No [] Diabetes Yes [] No []
Kidney disease Yes [] No [] Liver disease (including hepatitis) Yes [] No []
Arthritis Yes [] No [] High cholesterol Yes [] No []
Headaches Yes [] No [] Stroke Yes [] No []
Tuberculosis Yes [] No [] Eczema or other skin condition Yes [] No []

Any allergies? Yes [] No [] If YES, please specify:

Do you smoke? Yes [] No [] If YES, how many cigarettes per week:

Do you drink alcohol: No [] Occasionally? [] Regularly? Yes [] No [] Please specify how many units per week:

Do you suffer from any medical condition not listed above? Yes [] No [] If YES, please specify:

Are you currently taking any medication, prescribed or over the counter?: Yes [] No [] If YES, please specify overleaf.

General Practitioner:

Surgery Address:

Telephone number (including dialling code):

Dentist:

Surgery Address:

Telephone number (including dialling code):

To help us improve our service, please indicate how you found us by selecting one of the boxes below:

- [] Local Newspaper [] Yellow pages [] Clinical Denture Centre website
[] Recommendation from friend or family member [] Google [] Recommendation from dentist
[] Other – please specify:

The information provided above is correct to the best of my knowledge.

Signed: Date:

WILL YOU REQUIRE AN INVOICE TO SUPPORT A DENTAL INSURANCE CLAIM? YES [] NO []