BAMBURGH DENTAL OFFICE

Name (Mr. / Mrs./ Miss/ Ms.)_____

Residence Address Telephone: _____

_____

_____ Post Code _____

Occupation _____ Date of Birth ____/____/_____

Do you have Dental Insurance (YES/ NO)

If Yes: Police Number _____ Subscriber_____

Insurance company_____

Certificate Number_____

MEDICAL HISTORY

Family Physician: Dr._____ Telephone:_____

Please √ questions below

	YES	NO
• Are you presently under the care of a physician?	☐	☐
• Is your health perfect?	☐	☐
• Are you taking any medication or drug?	☐	☐
• Have you have an allergy (to any medications/ drugs)?	☐	☐
• Have you ever experienced bad reaction to local or general anesthesia?	☐	☐
• Do you have any blood disorders, or bruise easily?	☐	☐
• Have you ever had any injury, surgery or radiation therapy to your head or neck area?	☐	☐

Patient's Signature _____