Please fill out the following, if you need assistance, please ask for the receptionist.

Thank you.

**Personal Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: (H) \_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_ (M) \_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: \_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have insurance coverage? \_\_\_\_\_\_\_\_\_\_\_

If yes which is your provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In case of emergency, please contact**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: (H) \_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_ (M) \_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**:

Please indicate the most appropriate response

|  |  |  |  |
| --- | --- | --- | --- |
| Let’s Know You… | Yes | No | Not sure |
| **Diabetes**  Do you suffer from Sugar?  If yes, what medications are you taking? |  |  |  |
| **Hypertension**  Do you suffer from Pressure?  If yes, what medications are you taking? |  |  |  |
| **Cardiac Problems or suffering with Rheumatic Fever**  Do you suffer from heart disease?  If yes, what medication are you taking? |  |  |  |
| **Respiratory Diseases**  Do you have Sinusitis, Asthma, or Rhinitis?  If yes, what medication are you taking? |  |  |  |
| **Epilepsy**  Do you get fits?  If yes, what medication are you taking? |  |  |  |
| **Have you ever been infected by**  **COVID-19?**  If yes, how long ago were you infected? |  |  |  |
| **Have you been vaccinated against COVID-19?**  If yes, are you partially, fully, or fully and booster? |  |  |  |
| **Are you allergic to any medications?**  If yes, please indicate. |  |  |  |
| Have you ever been hospitalized?  If yes, please give details. |  |  |  |

**Agreement of Consent for Treatment and Payment.**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby give consent for treatment at Siparia Wellness Centre Ltd. I hereby also agree to the terms and conditions of payment of the relevant fees which will be associated with the delivery of the appropriate treatment after examination and consultation with the attending dentist or otherwise stated.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s/Parent’s/Guardian’s Signature Attending Dentist Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Witness