Clinical Denture Centre

16-17 Park Street, Deal CT14 6AG - Tel: 01304 380400 www.clinicaldenturecentre.co.uk

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 ☐

High blood pressure ..... Yes ☐ No ☐

Seizures/epilepsy ..... Yes ☐ No ☐

Kidney disease ..... Yes ☐ No ☐

Arthritis ..... Yes ☐ No ☐

Headaches ..... Yes ☐ No ☐

Tuberculosis ..... Yes ☐ No ☐

Lung problems (including asthma) ..... Yes ☐ No ☐

Low blood pressure ..... Yes ☐ No ☐

Diabetes ..... Yes ☐ No ☐

Liver disease (including hepatitis) ..... Yes ☐ No ☐

High cholesterol ..... Yes ☐ No ☐

Stroke ..... 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? ☐ Please specify how many units per week: .....

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

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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 ☐ Online advertising ☐ 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 ☐