Indicate which of the following you have had, or have at present? If yes, please tick.

☐	☐ Stroke	☐ Radiation Therapy	☐ Chest Pain
☐ Stomach Ulcers	☐ Chemotherapy	☐ Congenital Heart Disease	☐ Diabetes
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ High Blood Pressure	☐ Glaucoma
☐ Thyroid Problems	☐ Hemophilia	☐ Bruise easily	☐ Tuberculosis
☐ Mitral Valve Prolapse	☐ Emphysema	☐ Liver Disease	☐ Asthma
☐ Artificial Heart Valve	☐ Kidney Trouble	☐ Chronic Cough	☐ Tumors
☐ Epilepsy or Seizures	☐ Cortisone Medicine	☐ Latex Sensitivity	☐ Sinus Troubles
☐ Arthritis/Rheumatism	☐ Swollen Ankles	☐ Neurological Disorders	☐ HIV/AIDs
☐ Fainting or Dizzy Spells	☐ Rheumatic Fever	☐ Hepatitis	☐
☐ Artificial Joints (hip, knee, etc.)	☐ Heart Pacemaker	☐	☐

Are you: Pregnant? ___________ If yes, how many months _______________
Nursing? __________

Are you taking any Medication? __________
If yes, please state all medication that you are taking____________________________

Any known allergies to penicillin Y / N

- **Other antibiotics Y / N**
- **Local Anesthetics Y / N**
- **Other Y / N If Yes please indicate: ______________**

FINANCIAL

Person responsible for paying this Account: ____
Preferred Method of payment: Cash: ___ EFTPos: ___ Credit Card: ___ Visa: ____ Other: ______

All accounts are to be settled after each treatment.
Please note, that any costs that may be incurred to recover any debts outstanding may be added to your final dental account. Any General Remarks: ____

By signing here, I indicate that I have understood and am fully informed to the contents of this document. Further, I consent to any authorized Dental Health-care, including administration of local anesthesia, X-ray examination and other related dental procedures provided by the Professional and Auxiliary Dental staff of Peninsula Dental Centre.

Signature: ______________________________________ Date: ______________________