SPECIALIST DENTAL GROUP®
PATIENT INFORMATION FORM

Title: Prof/Dr/Mr/Mrs/Ms
NRIC/Passport: _____ Date of birth (*dd/mm/yyyy*): _____
Name (*as in NRIC/Passport*): _____
Gender: Male/Female Nationality: _____
Occupation: _____ Language Spoken: _____
Home Address: _____
Country: _____ Postcode: _____
Tel (*work/home*): +( ) _____ Tel (*mobile*): +( ) _____
Email: _____

In case of an emergency, please provide a contact name and contact details.

Name: _____ Relationship: _____ Tel: _____

How did you find out about us?

☐ Online Search ☐ Media Coverage ☐ Parkway
☐ Family/Friend ☐ Talk/Conference ☐ Doctor Referral: _____
☐ Print Advertisement ☐ Walk in ☐ Others: _____

Medical History and Health Status

Please provide the following information to help us better understand your medical history and your current health status. Have you been treated / hospitalised for:

Heart / Cardiac trouble	(Y/N)	Kidney Problem	(Y/N)
Diabetes	(Y/N)	Lung Problem	(Y/N)
High blood pressure	(Y/N)	Liver Problem	(Y/N)
Bleeding problem	(Y/N)	Rheumatic fever	(Y/N)
Hepatitis	(Y/N)	Sinus Problem	(Y/N)
Asthma	(Y/N)	HIV / STD	(Y/N)
Allergies	(Y/N)	Mental / Psychological disorders	(Y/N)
Respiratory problems	(Y/N)	Others (*Please specify*) _____	

Are you on any medication? (Y/N). If yes, please specify: _____

Do you have drug allergies/other allergies? (Y/N). If yes, please specify: _____

For ladies: Are you pregnant or think you may be pregnant? (Y/N)

If you have an illness that is not indicated above, or changes to your medical history after today, please inform us before starting dental treatment.

Please tick accordingly.

☐ ***Specialist Dental Group may use this information for purposes deemed relevant to my dental care.***
☐ ***Specialist Dental Group may send me relevant marketing messages related to my dental care.***

Signature: _____ Date: _____

We respect your privacy and treat all information that we receive from you as confidential and part of your medical records.

Our Clinics
Orchard: Mt Elizabeth Medical Centre, 3 Mt Elizabeth, #08-03/08-04/08-10, Singapore 228510 tel 65 6734 9393 fax 65 6733 6032
Gleneagles: Gleneagles Medical Centre, 6 Napier Road, #07-17, Singapore 258499 tel 65 6471 5150 fax 65 6471 0681