



“Quality with a smile”

Welcome to *Kurer, Jackson, Jotkowitz Dental office*

Please help us to get to know you better:

First name:		Family Name:	
Home Address:		Home #	
Marital Status: Married/Single/Divorced/Widow		Work #	
Date of birth: D/M/Y __ __/ __ __/ __ __		Mobile #	
I.D.		Additional contact #	
E-Mail			
Who may we thank for referring you?			
MEDICAL HISTORY			
Allergies: Penicillin, other:			
Medicine taking:			
Do you suffer from			
Heart Problems: Murmur /Other	Y / N	Kidney Problems	Y / N
Valve Replacement	Y / N	Hepatitis/Jaundice	Y / N
Anemia	Y / N	Asthma	Y / N
High/Low Blood pressure	Y / N	AIDS	Y / N
Clotting problems	Y / N	Psychiatric Diseases	Y / N
Rheumatic Fever	Y / N	Do you smoke	Y / N
Diabetes	Y / N	Other	
FOR WOMEN ONLY ♀			
Are you pregnant?	Y / N	If so what month	
Are you taking hormones / contraceptive pills?			Y / N
DENTAL HEALTH 😊			
When was you last dental examination?			
What oral hygiene routine do you follow?			
Do you suffer from			
Gag reflex	Y / N	Bad Mouth Odor	Y / N
Grinding/ Clenching	Y / N	Have you undergone dental surgery?	Y / N
Is anything bothering you at the moment?			
Would you like your teeth to be whiter?			
Why did you leave your last dentist?			

If you have any questions regarding the above form please do not hesitate to ask a member of our team or your doctor

SIGNATURE_____

DATE____/____/____