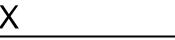


## NO 49 OSU BADU STREET DZORWULU ACCRA GHANA. (233) 0302-771155 / 0302-771156

Patient Na	ime							
		First	Midd	lle		Last	Title	Preferred Name
Address _								
<b></b>						<b>.</b>		
City		Region				Ghana I	Post Address	
Home Pho	one		Mobile Ph	none _			Email	
Gender	□ Male □	Female	Birthda	y (Mon	th/Day/Y	ear)		
				, ,		,		
Check App	ropriate Box	☐ Minor	☐ Single		/larried	☐ Divorce	d 🛮 Widowed	d   Separated
Patient or	narent's emplo	ver			Work	nhone		
i aticiit oi	parent 3 emplo	,ycı			****	prioric		•
Business a	ddress/ Branch			Cit	ty			
Person to	contact in case	of an emerg	gency			Phone		<del></del>
How did y	ou hear of us?	☐ Internet	: 🛮 Facebo	ok/Twi	tter 🛚	Dental Educ	ation Session	Referred by
Who will h	oe paying your b	sill2 Solf	Othor					
VVIIO VVIII L	be paying your t	Jiii: Jeii	Other					
Responsib	le Party							
i.	-	Responsible	for paying b	ill			Rela	ationship to Patient
		·		Name				•
	Address				Phone			
	Email Addres	ss						
	Employer		W	ork Pho	ne			
	Is this persor	n currently a	patient in o	ur clinic	? Yes	No		
ii.	My Employ	vor is rospo	nsible for pa	vina m	, hill: Car	nnany Infor	mation	
""					, biii. Coi	iipaiiy iiiioii	nation	
		. ,						
		number		•••••				
	Stall ID Nu	IIIDEI		•••••				
iii.	My Insura	nce is respo	nsible for pa	ying my	y bill .			
	Name of Ir	nsurance Co	mpany			Name of In	sured	
			to patient_					
			Insura					
							<del></del>	
					_			<del>-</del>



Signture of patient (or parent, if minor)

Date		

## **Medical History**

Please ti	ck Yes or	No (If Yes, plea	se fill in details)			
☐ Yes	□ No	Are you taking	any medication?			
☐ Yes	□ No	Are you allergic to any medication?				
☐ Yes		Do you have a history of a major illness?				
☐ Yes			any operations?			
☐ Yes	Пио	Have you ever	been involved in a serious	accident?		
☐ Yes			a physician in the last 12 m			
_		,	, , , , , , , , , , , , , , , , , , , ,	,		
Circle anv	of the m	edical conditions	below that you have had or cu	urrently have.		
-		/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia	
Anemia		'	Dizziness	Herpes	Prolonged Bleeding	
Arthitis			Epilepsy	High Blood Pressure	Radiation/Chemotherapy	
Asthma o	r Hayfeve	r	Gastrointestinal Disorders	HIV/Aids	Rheumatic Fever	
Bone Disc	orders		Heart Problems	Kidney problems	Tuberculosis	
Congenita	al Heart D	efect	Heart Murmur	Nervous Disorders	Tumor or Cancer	
			Dental F	listory		
What con	cerns you	ı most about you	r teeth?			
What was	done at	the time?			<del></del> _	
☐ Yes	☐ No		ly in any dental pain?			
☐ Yes	☐ No	Have you ever experienced any unfavorable reaction to dentistry?				
☐ Yes	☐ No	Have you ever lost or chipped any teeth?				
☐ Yes	☐ No	Have there been any injuries to face, mouth, or teeth?				
☐ Yes	☐ No	Is any part of your mouth sensitive to temperature? Where?				
Yes	■ No	Is any part of your mouth sensitive to pressure? Where?				
Yes	■ No	Do your gums bleed when you brush or floss?				
☐ Yes	☐ No	Do you have any type of thumb or tongue habit?				
☐ Yes	☐ No	Are you a mouth breather?				
☐ Yes	□ No	Are you concerned about bad breath?				
☐ Yes	☐ No	Do your teeth or jaws ever feel uncomfortable when you wake up in the morning?				
☐ Yes	☐ No	Are you aware of your jaw clicking or popping?				
☐ Yes	□ No	Have you ever b	een told that you grind your to	eeth?		

Yes	□ No	Do you have "tension" headaches?				
Yes	☐ No	Have you ever experienced chronic ringing in your ears?				
☐ Yes	□ No	Please list some hobbies or interests				
Female P	atients o	nly:				
☐ Yes	□ No	Are you taking any oral contraceptives?				
☐ Yes	□ No	Are you pregnant?				
☐ Yes		Are you nursing?				
Additional		ents else that you would like the dentist to know?				
Signatur	·e:		Date:			