ADVANCED DENTAL CARE CENTRE LIMITED
LP #18 Caroni Savannah Road, Chaguanas. Trinidad West Indies
Tel: 868 665 6455

PLEASE COMPLETE ALL FIELDS
On completion of this form, please email to: service@advadent.com

Patient Information

Patient Name: _____ Date: _____ dd/mm/yyyy

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other:

Birth Date: _____ dd/mm/yyyy

Phone (Home): _____ (Work): _____ Ext.: _____ Cell/Other No. _____

E-mail: _____
BLOCK LETTERS PLEASE

Address: _____
STREET

_____
CITY

(I.C.E.): _____ (I.C.E.): _____
IN CASE OF EMERCENCY CONTACT NAME **IN CASE OF EMERGENCY CONTACT NUMBER**

Health Information

Date of Last Dental Visit: _____ dd/mm/yyyy Reason for this visit: _____

Check this box if you require a confidential medical history interview with the Doctor: ☐

Do you have or ever had any of the following? Please check those that apply:

☐ HIV/AIDS	☐ Epilepsy	☐ Kidney Disease	☐ Stomach Problems
Last test date:_____ dd/mm/yyyy	☐ Excessive Bleeding	☐ Liver Disease	☐ Stroke
☐ Allergies	☐ Fainting	☐ Mental Disorders	☐ Tuberculosis
Eplain:_____	☐ Glaucoma	☐ Nervous Disorder	☐ Tumors
☐ Anemia	☐ Growths	☐ Pacemaker	☐ Ulcers

☐ Arthritis	☐ Hay Fever	☐ Pregnant -currently	☐ Venereal Disease
☐ Artificial Joints	☐ Head Injuries	Due Date: dd/mm/yyyy	☐ Codeine Allergy
☐ Asthma	☐ Heart Disease	☐ Radiation Treatment	☐ Penicillin Allergy
☐ Blood Disease	☐ Heart Murmur	☐ Respiratory Problems	Other: ☐
☐ Cancer	☐ Hepatitis	☐ Rheumatic Fever	
☐ Diabetes	☐ High Blood Pressure	☐ Rheumatism	
☐ Dizziness	☐ Jaundice	☐ Sinus Problems	

Are you currently taking any medication? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X _____ Date: _____

Signature of patient, parent or guardian dd/mm/yyyy

Referral Information

Whom may we thank for referring you to our practice?

☐ Another patient ☐ Friend ☐ Relative

☐ Dental Office ☐ Yellow Pages ☐ School

☐ Work ☐ Social Media: _____ ☐ Other:_____

Name of person or office referring you to our practice:

Person Responsible for Payment

The following is for: the person responsible for payment ☐ Self ☐ Other

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Phone (Home): _____ (Work): _____ Ext.: ____ Best time to call: _____

Employment Information

Employer Name: _____ Occupation: _____

Address: _____

STREET CITY

On completion of this form, please email to: **service@advadent.com**

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. We accept cash, credit cards, linx and cheque.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services.

I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended.

I grant my permission to you or your assignee to perform all necessary diagnostic investigations which may include x-rays and photographs and to telephone me at home, work or mobile to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

X _____ _____

Signature of patient, parent or guardian | Relationship to Patient

***Aesthetic consent*:**

I consent and authorize Dr Curtis Sealy to use any photographs, or any other images of me before, during or after treatment, without my given name, for advertising, education, or any other lawful purpose and I release and forever discharge him from any claim, demands, or liability on account of such use or for the quality of the reproduction of the photograph or photocopy provided.

X _____

Signature of patient