Tam, Hulac
& Partners Dental Ltd.

Date: _____

Patient Number: _____

Personal Information

(Mr / Mrs / Ms / Mstr)

Last Name _____ First Name _____

Date of Birth ___ / ___ / ___ (dd / mm / yy) Gender M ○ F ○

Office Address _____ Tel _____

Home Address _____ Tel _____

Mobile _____ HKID No. _____

Email _____ Referred By _____

Occupation _____

Emergency Contact

Contact Person _____

Relationship _____ Emergency Contact Number _____

Medical History

	Yes	No
Rheumatic Fever	○	○
Asthma	○	○
Chest (e.g. Bronchitis, TB)	○	○
Jaundice or Hepatits	○	○
Gastro-Intestinal	○	○
High Blood Pressure	○	○
Heart Pacemaker	○	○
Heart Problems	○	○
Drugs / Medication prescribed	○	○

Please specify: _____

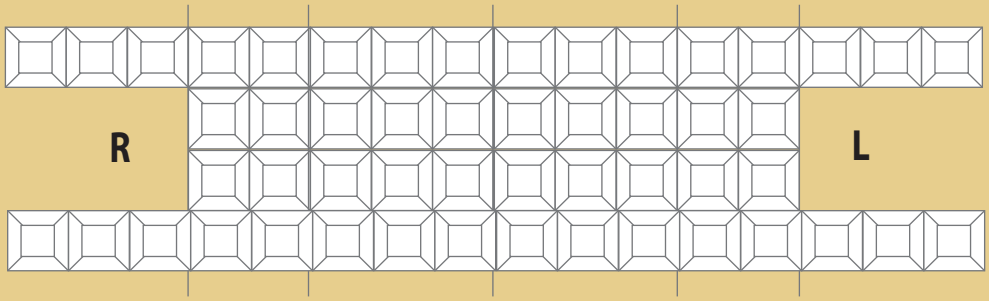
_____

	Yes	No
Diabetes	○	○
Epilepsy	○	○
Allergies (to_____)	○	○
Prolonged Bleeding	○	○
Pregnant (at Present)	○	○
Smoking (frequency:_____)	○	○
Alcohol (frequency:_____)	○	○
A.I.D.S./H.I.V	○	○
Major Surgery/Hospitalization	○	○

Others : _____

_____

I certify that the above information is complete and accurate. **Signature:**_____



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Notes