Confidential Patient Details and Medical Status Form

Quirke Dental Surgeons

To obtain the best and safest treatment, your dentist needs to know of any problems that may affect your treatment.

TITLE FIRST NAME SURNAME

Date Of Birth **SEX:** M☐ F☐ **EXPECTANT MOTHER:** ☐YES ☐NO

Address Eircode

How long since your last dental visit?

Mobile **Home** **Work** **e-mail**

YOUR GP'S NAME & ADDRESS

ARE YOU:

- Attending or receiving treatment from your doctor ☐, hospital clinic ☐ or specialist☐? NO ☐
- Details of illness or other issues
-
-

- Taking any medicines from your doctor (Tablets☐, creams☐, ointments☐, injections☐)? NO ☐
- Names of medications
-
-

- Allergic to any medicines☐ or materials☐? Please specify: NO ☐

HAVE YOU: *tick as appropriate*

- AIDS ☐ or are you HIV positive ☐ MRSA ☐ Hepatitis B ☐ or Hepatitis C ☐ ? NO ☐
- Heart problem ☐ a pacemaker ☐ angina ☐ blood pressure ☐ had a heart attack ☐ heart surgery ☐? NO ☐
- Had rheumatic fever ☐ a bad reaction to a general or local anaesthetic ☐ or had any joint replacement ☐? NO ☐
- Arthritis☐ Osteoporosis ☐ Endocarditis ☐? Been hospitalised for any reason ☐? NO ☐
- Bronchitis☐ Asthma☐ any other chest condition☐ Diabetes ☐ Epilepsy ☐ ? NO ☐
- Had treatment for cancer☐ taken steroids in the last 2 years ☐ carry a warning card ☐ NO ☐
- Do you smoke ☐? If so, how many per day? NO ☐
- Do you take Warfarin ☐? Bruise easily ☐ or have you bled excessively following a tooth extraction ☐? NO ☐
- Are there any other aspects concerning your health that you think the dentist should know ☐? NO ☐
- Any other details

DENTAL STATUS

Do you have any active dental problem at the moment?……..Yes ☐ No ☐
Have you noticed bleeding, swelling or any other problem with your gums?……Yes ☐ No ☐
Do you suffer from bad breath, bad taste or both?……...Yes ☐ No ☐
Are there any aspects of your smile that you are not happy with?……...Yes ☐ No ☐
Do you wish to have whiter teeth?……Yes ☐ No ☐
Do you grind or clench your teeth, either when awake or asleep?……Yes ☐ No ☐
Do you suffer from migraine or tension headaches?……Yes ☐ No ☐
Are you nervous or anxious about dental treatment?……Yes ☐ No ☐
Do you snore?.....Yes ☐ No ☐

If you are a new patient to this practice, how did you hear about us?……..

Completed by self/parent: Signature:_____ Date:_____

☐ tick this box if you do not wish us to send sms/email appointment reminders or other information about our services.