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81 Lower Kilmacud Road
Stillorgan
Co. Dublin

(01) 283 4036

wicklow
1 Church Street
Wicklow Town
Co. Wicklow

(404) 20 903

wexford
34 McCurtain Street
Gorey
Co. Wexford

(503) 9422888

Patient Medical Form

1. Patient Information

Name: .... Mobile Phone Number: ....

Address: .... Home Phone Number: ....

.... Patient's Dentist: ....

Email: .... Patient's Physician: ....

D.O.B: .... Referred by: ....

2. Family Information

Mother's Name: .... Mother's Phone Number: ....

Father's Name: .... Father's Phone Number: ....

Person in charge of account: ....

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated

3. Medical History

Is patient in good health? ☐ Yes ☐ No

Please check any of the following diseases for which the patient has been treated:

☐ Anemia	☐ Fainting/Dizziness	☐ Nervous Disorders
☐ Asthma	☐ Glaucoma	☐ Pneumonia
☐ Bone Disorders	☐ Heart Disease	☐ Prolonged Bleeding
☐ Diabetes	☐ Hepatits	☐ Rheumatic Fever
☐ Endocrime Problems	☐ Kidney Disease	☐ Tuberculosis
☐ Epilepsy	☐ Liver Disease	☐ Other

Have there been any injuries to the face, mouth or teeth? ☐ Yes ☐ No

Has the patient ever sucked a thumb or fingers? ☐ Yes ☐ No Until what age? _ _

Does the patient have any speech problems? ☐ Yes ☐ No

Has the patient reached puberty? ☐ Yes ☐ No At what age? _ _

Have the tonsils and adenoids been removed? ☐ Yes ☐ No At what age? _ _

List any allergies or drug sensitivities: ....

List any drugs or medications currently being taken: ....

Does the patient have a tendancy to suffer from: ☐ Colds ☐ Sore Throats ☐ Ear Infections

Approximate date of last dental checkup: ....

Reason for consultation: ....

Date .... Signature ....