MD
Mullane Dental
COSMETIC | ORTHODONTICS | IMPLANTS

PLEASE COMPLETE FRONT AND BACK OF PAGE

Title ……. First Name…… … Surname……. D.O.B…….

Contact Number:……..Email Address:……

Address:……

Who recommended you to the practice (New Patient's): …….

Employers name…… Occupation: ……..

PPS Number: …… Medical Card Number …… Expiry Date ……

Emergency Contact Name: …… ***Relationship:*** ……..
Number: ……

If you wish to nominate an Authorized Contact please note the details below

Authorized Contact Name: …….. ***Relationship:*** ……..

Number: ……..

The following information is required to enable us to provide you with the best possible dental care, All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. When was your last medical checkup? ……Name of GP ……..

2. Are you being treated for any medical condition at present or have you been treated within the past year? **If so \why**

   Yes □ No □ Not sure/Maybe □

3. Are you taking any medications, non-prescription drugs or herbal supplements of any kind?

   If yes please list Yes □ No □

   LIST

4. Do you have any allergies? If you answered yes, please list using the categories below

   Yes □ No □ Not sure/Maybe □

   a) Medications (e.g. penicillin)
   b) b) Latex/rubber products
   c) c) Other(e.g. hay fever/food)

5. Have you ever had a peculiar or adverse reaction to any medicines or injections? **If yes please explain.**

   Yes □ No □ Not sure/Maybe □

6. Do you have or have you ever had asthma?

Yes □ **No** □ **Not sure/Maybe** □

7. Do you have or have you ever had any heart or blood pressure problems?

Yes □ **No** □ **Not sure/Maybe** □

8. Do you have or have you ever had a repair or replacement of a heart valve, an infection of the heart (i.e. infective endocarditis) a heart condition from birth (i.e. congenital heart disease) or a heart transplant

Yes □ **No** □ **Not sure/Maybe** □

9. Do you have a prosthetic or artificial joint? **Yes** □ **No** □

10. Do you have any conditions or therapies that could affect your immune system, e.g. Leukemia, AIDS, HIV infection, radiotherapy, Chemotherapy **Yes** □ **No** □ **Not sure/Maybe?** □

11. Have you ever had Hepatitis .Jaundice or liver disease? **Yes** □ **No** □ **Not sure/Maybe** □

12. Do you have a bleeding disorder**?** **Yes** □ **No** □ **Not sure/Maybe** □

13. Have you ever been hospitalized for any illness or operations/ **If yes please explain**

Yes □ **No** □ **Not sure/Maybe** □

14. Do you have or have you had any of the following? **Please check**

Chest pain □ Rheumatic Fever □ Pacemaker □ Steroid Therapy□ Seizures/epilepsy □

Osteoporosis medications (e.g. Fosamax, Actonel) □

Heart attack □ Mitral valve Prolapse □ Lung disease □ Diabetes □ Kidney disease □

Stroke □ Tuberculosis □ Stomach Ulcers □ Thyroid disease □ shortness of breath □

Heart Murmur □ Cancer □ Arthritis □ Drug or alcohol dependency □

15. Are there any conditions or diseases not listed above that you have or had? If not what conditions?

Yes □ **No** □ **Not sure/Maybe** □

16. Do you smoke or chew tobacco products **Yes**□ **No** □

17. Are you nervous of dental treatment **Yes** □ **No** □ **Not sure/Maybe?** □

18. FOR WOMEN ONLY Are you breastfeeding or pregnant? If pregnant, what is your expected delivery date ……

To the best of my knowledge the above information is correct

Patient / Parent or Guardian Signature …….. Date ……