

THE
New Smile
DENTAL CLINIC
www.newsmiledentalclinic.ie

Getting to know you...

Name: _____.

Date of Birth: _____.

Address: _____.

_____.

_____.

Phone: (home): _____.

(work): _____.

(mobile): _____.

Doctor: _____.

Spouse/Parent: _____.

Do you have Insurance (VHI,BUPA,VIVAS): _____.

RSI Number: _____.

Medical Card: _____.

Please turn over for medical history:

Medical History:

Are you under the care of a Doctor? Yes/No
Are you now taking any medicines? Yes/No
If Yes, please list below:

Are you allergic or sensitive to anything?
(eg drugs, anaesthetic, penicillin, latex) Yes/No

Do you smoke? Yes/No
Females Only: Are you pregnant? Yes/No

Do you have or have you had (circle):

Heart Trouble	Diabetes	Fainting spells
Rheumatic Fever	Arthritis	Epilepsy
Asthma	Heart Murmur	Blood Pressure
Artificial heart valve	Pacemaker	Liver disease
Bleeding problems	TB	Cancer
Thyroid disease	Radiotherapy	Stroke
Stomach problems	Hepatitis	Kidney disease
Sinus problems	Breathing problems	

Remarks: _____

Signed: _____
Date : _____