CONTACT DETAILS:	NAME	
	DOB	
	TELEPHONE: MOBILE HOME	
	ADDRESS	
	EMAIL	
Emergency Contact {please provide name and phone number}		
Name of your GP Contact details of your GP		
PPS NUMBER		

MEDICAL HISTORY:

Have you ever had any of the following? Please tick those that apply:

○ Anaemia	○ Fainting	○ Pacemaker
○ Artificial Joints	○ Glaucoma	○ Radiation Therapy
○ Asthma	○ Heart Disease	○ Respiratory Problems
○ Blood Disease	○ Heart Murmur	○ Rheumatic Fever
○ Cancer	○ Hepatitis A,B, C	○ Sinus Problems
○ Dizziness	○ Jaundice	○ Stroke
○ Epilepsy	○ Kidney Disease	○ Tuberculosis
○ Excessive Bleeding	○ Liver Disease	○ Tumours
○ Diabetes	○ HIV/AIDS	○ Psychological Disorders

ARE YOU PREGNANT? **IF YES, HOW MANY MONTHS?**	
Have you undergone any medical operations?	YES NO Details:
Are you currently taking any Medications or tablets regularly?	YES NO Details:
Do you have any allergies to Penicillin or other drugs/Materials ?	YES NO Details:
Is your Blood Pressure normal, High or Low?	
Do you smoke? -*If yes, How many per day?*	

Consent for services;

I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics, IV sedation or relative analgesia as indicated and I will assume responsibility for the fees associated with those procedures. I understand that the practice requires at least 24 hours notice if I need to cancel my scheduled appointment. I hereby consent to the use of any study models, X-rays, computer images and photographs at various dental seminars, lectures and publications that the dentists may author. I am aware that payment is required on the day of treatment. I consent to the use of my personal details under new Data Protection regulations, which can be found at www.nostradental.ie or displayed in office.

Signed: _____ Date: _____