



## Dental Questionnaire

In order to provide you with the best treatment and to enable us to treat you safely, we ask for information about your general health. Please complete and sign the form below and hand it to a member of our team. All information will be kept strictly confidential.

First Name: \_\_\_\_\_ Address: \_\_\_\_\_

Surname: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_

PPS Number: \_\_\_\_\_ Doctor's Details: \_\_\_\_\_

& Telephone \_\_\_\_\_

Medical Card # \_\_\_\_\_

Occupation: \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? – please tick			
<i>Friend/Family</i>	<input type="checkbox"/>	<i>Whatclinic.com</i>	<input type="checkbox"/>
<i>Advertising</i>	<input type="checkbox"/>	<i>Flynnsdentalcare.ie</i>	<input type="checkbox"/>
<i>I.T. Tralee</i>	<input type="checkbox"/>	<i>Google</i>	<input type="checkbox"/>

### ARE YOU CURRENTLY:

YES NO

PLEASE GIVE DETAILS

Receiving treatment from a doctor, hospital or clinic?

☐☐

\_\_\_\_\_

Taking any tablets/ medicines?

☐☐

\_\_\_\_\_

Carrying a medical warning card?

☐☐

\_\_\_\_\_

### FOR WOMEN:

YES NO

Estimated Date of Delivery

Are you / Could you be pregnant?

☐☐

\_\_\_\_\_

(Please Complete Both Sides of this Form)

**ARE YOU ALLERGIC TO:****YES****NO****PLEASE GIVE DETAILS**

Penicillin or any other drug or medicine?

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Latex or other materials?

☐☐

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**HAVE YOU OR DO YOU SUFFER FROM:****YES****NO****PLEASE GIVE DETAILS**

Fainting, blackouts or epilepsy?

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Asthma?

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Heart problems, angina, blood pressure or stroke?

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Diabetes?

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Arthritis?

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Bruising or persistent bleeding after an injury,  
tooth extraction or surgery?☐☐

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Any infectious diseases (including HIV and  
Hepatitis)?☐☐

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**HAVE YOU EVER HAD:****YES****NO****PLEASE GIVE DETAILS**

Rheumatic fever?

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Liver disease (e.g. jaundice, hepatitis) or kidney  
disease?☐☐

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Any other serious illness or operation?

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A bad reaction to general or local anaesthetic?

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A joint replacement or other implant?

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Treatment that required you to be in hospital?

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Heart surgery / Brain surgery?

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**SOCIALLY:****YES****NO****AMOUNT**

Do you drink alcohol?

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**YES****NO****PAST****AMOUNT**

Do you smoke?

☐☐☐

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**FORM COMPLETED BY:**

Self

☐

Parent

☐

Guardian

☐**SIGNATURE:** 

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**DATE:** 

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