Camlough
DENTAL PRACTICE

W. F. Campbell BDS
A. M. Campbell BDS

Name ____________________ **Known as**____________________
Address____________________
Postcode __________ **Telephone** ____________________ **Date of Birth** __________
Email address ____________________
Next of Kin ____________________ **Contact number** ____________________
Doctors name & address ____________________
____________________ **Telephone** ____________________

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How did you hear about us? ____________________

How long since your last dental treatment? ____________________

	Yes	No	Details
Are you taking or have you recently taken any medicines, tablets, creams or inhalers from your doctor? *(Please list)*	☐	☐	
Are you attending the hospital or doctor for any reason?	☐	☐	________
Are you allergic to anything?	☐	☐	________
Do you carry a medical warning card?	☐	☐	________
Do you smoke?	☐	☐	
How often do you consume alcohol?			________
Have you ever had:			
- Rheumatic fever?	☐	☐	________
- Heart problems/blood pressure?	☐	☐	________
- Epilepsy/blackouts?	☐	☐	________
- Diabetes?	☐	☐	________
- Kidney problems?	☐	☐	________
- Hepatitis/liver disease/HIV?	☐	☐	________
- Jaundice?	☐	☐	________
- Osteoporosis?	☐	☐	________
- Rheumatoid arthritis?	☐	☐	________
- Cancer?	☐	☐	________
Have you ever been advised you are at increased risk of CJD for public health purposes.	☐	☐	________
Are you pregnant?	☐	☐	________
Do you bleed excessively if cut?	☐	☐	________
Have you had any blood test/transfusions lately?	☐	☐	________
Have you had any steroids in the last 2 years?	☐	☐	________
Are there any other issues regarding your health you wish to discuss with the dentist?	☐	☐	________

Signature ____________________ **Date** ____________
Dentist Signature ____________________ **Date** ____________