2nd Floor
17 Main Street
SWORDS
Co Dublin

SWORDS ORTHODONTICS

www.swordsortho.com

t: 01 810 7622
f: 01 807 5220
e: swordsorthoinfo@gmail.com

Personal Details

Name		Telephone Numbers	
Address		Home	
		Mobile	
		Work	
		Date of Birth	

Family Dentist Name:	Date of Most Recent Visit (approx)
Family Doctor Name:	Date of Most Recent Visit (approx)

Where did you hear about Swords Orthodontics?
(If it's someone we know – like a Swords Ortho patient/local dentist– please let us know who)

Medical History

(Circle as appropriate)

Do you:

Have any allergies..... **YES** **NO**

Have any history of heart murmur, rheumatic fever or any other kind of heart condition..... **YES** **NO**

Have any history of asthma or any other kind of breathing or respiratory problem..... **YES** **NO**

Take any medication/inhalers..... **YES** **NO**

Have you:

Any bleeding disorder or tendency..... **YES** **NO**

Always been in good health ..... **YES** **NO**

Ever taken any pills/medicines/tablets..... **YES** **NO**

Ever been in hospital..... **YES** **NO**

Ever had a general anaesthetic..... **YES** **NO**

A history of diabetes (self or family)..... **YES** **NO**

Ever had hepatitis or jaundice..... **YES** **NO**

Ever been referred to a consultant/specialist... **YES** **NO**

Are you :
(or might you be) pregnant..... **YES** **NO**

(If you selected YES to any question, please give further details in this box, thank you – include details of any medicines/tablets/inhalers)

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DATE:
Signature:

(If you're signing on behalf of patient, please print name and state relationship to patient as well as signing)