Patient Medical History

TITLE .....NAME.....D.O.B.....AGE.....

ADDRESS: POSTCODE:	TEL: MOBILE: EMAIL:

NAME/ADDRESS OF G.P

DO ANY OF THE FOLLOWING CURRENTLY APPLY TO YOU

HEART CONDITION		UNDERGONE ANY OPERATIONS IN THE LAST 2 YEARS	
ASTHMA		DEMENTIA / MEMORY LOSS	
MEDICAL WARNING CARD		ADHD / AUTISM	
ANY ALLERGIES EG-PENICILLIN		ANXIETY / PANIC ATTACKS	
DIABETES		DEPRESSION / MOOD SWINGS	
BLEEDING DISORDER / BLOOD THINNERS		HEARING IMPAIRMENT	
HIGH BLOOD PRESSURE		LEARNING DISABILITY	
INFECTIOUS DISEASES ie HIV		EATING DISORDER / WEIGHT ISSUES	
EPILEPSY		MOBILITY ISSUES	
CANCER		REFLUX	
LIVER DISEASE			
PREGNANT		CAN YOU CLAIM BACK DENTAL FEES?	
IS THERE ANYTHING YOU WOULD LIKE TO TELL THE DENTIST PRIVATELY		ANY OTHER CONDITION NOT LISTED HERE	

ARE YOU TAKING ANY MEDICATION PLEASE LIST HERE

DO YOU PAY FOR TREATMENT YES/NO
IF NO WHAT IS YOUR EXEMPTION.....

NEXT OF KIN

OCCUPATION

IF UNDER 16 WHICH SCHOOL IS ATTENDED

SIGNED..... DATE.....

I have read and understood the Privacy notice and give my consent for my personal data to be used accordingly ☐

I am happy to be contacted by Phone ☐ Text ☐ Email ☐ Letter ☐

Please turn over and fill out other side