Confidential Medical History Form

Please use BLOCK CAPITALS

Full Name		
Date of Birth		Your GP's details
Address	Telephone numbers - Home: Work: Mob:	
E-Mail Address		

Please let us know how you would like to be contacted about Recalls and Appointments Reminders

Phone	Text	E-Mail

*Please put **Yes** or **No** as appropriate, and give relevant details.*	**Yes/No**	**Details**
Are you currently pregnant? (If so, please give due date.)		
Are you currently taking any prescribed medication (e.g. tablets, ointments, including contraceptives and hormone replacement therapy)?		
Are you currently receiving treatment from a doctor, hospital, or clinic?		
Are you taking, or have you recently taken any form of steroids?		
Have you ever had treatment that required you to stay in hospital? Has this involved surgery?		
Have you ever had brain, middle ear, or bowel surgery?		
Have you ever had rheumatic fever?		
Have you ever had liver disease (e.g. jaundice, hepatitis) or kidney disease?		
Have you been told that you have a heart murmur or problem, stroke, angina, blood pressure, or had any form of heart surgery or had a pacemaker fitted?		
Have you ever had a bad reaction to general or local anaesthetic?		
Have you ever had a joint replacement or any other implant?		
Do you carry a medical warning card or Bracelet?		
Do you suffer from asthma or chest conditions if so do you have an inhaler and if so do you have it with you?		
Do you suffer from any allergies to medicines (e.g. penicillin), substances (e.g. latex or rubber), or foods?		
Do you suffer from bronchitis, asthma or other chest conditions?		
Do you Smoke?		
Do you suffer from fainting attacks, blackouts, or epilepsy?		
Are you diabetic (or is anyone in your family)?		
Do you suffer from bruising or persistent bleeding following injury, tooth extraction, or surgery?		
Do you suffer from any infectious diseases (including HIV and hepatitis)?		
Do you suffer from rheumatism or arthritis?		
Is there any other information that your dentist might need to know about?		

There will be a charge for any appointments that you fail to attend, or cancel with less than 24 hours notice

Signature (Self / parent / guardian) Date

PLEASE TURN OVER AND SIGN OTHER SIDE OF PAGE ALSO

PLEASE SIGN ONE OF THE FOLLOWING

I WISH TO BE TREATED PRIVATELY

Signed………………………………………………...…..

I WISH TO BE TREATED USING P.R.S.I. Contributions.
Currently only 1 examination every 12 months is covered under this scheme.
No treatment is covered under this scheme following Budget 2009
Examination can only be provided where a valid P.R.S.I. number has been provided and entitlement to benefit has been confirmed.

Signed ………………………………………………..

P.R.S.I. No: ________________________________

WE REGRET IT IS NO LONGER POSSIBLE TO PROVIDE TREATMENT UNDER DTSS / MEDICAL CARD SCHEME