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 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?		

As part of your dental treatment we may need to take X-Rays. By signing below you give your consent for any necessary X Rays to be taken.

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

FOR PATIENTS WITH PRSI BENEFIT, PLEASE SIGN CONSENT FORM BELOW

TREATMENT BENEFIT CONSENT

Name: ___________________ PPSN _____________ D.O.B.

Please tick box the appropriate box

Employed ☐ Self Employed ☐

I the undersigned, authorise Ken Heritage Dental Practice to use my personal data for the purposes of checking my eligibility for Treatment Benefits and to allow for the processing of the payment claim in respect of treatments I have received.

I understand that I may revoke this consent at any time by contacting the Department.

Signature of patient: ____________________

Signature on behalf of dental practice: ___________________

Date: __________________

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