

MEDICAL UPDATE FORM

Title: (Please tick) Mr Ms/Miss Mrs Mst

Surname: _____ First Name: _____ D.O.B: ____/____/____

Has your address changed in the last year? Yes / No

If yes, home address: _____ Postcode: _____

Phone No: _____ Mobile: _____

Business address: _____

Business phone no: _____ E-mail Address: _____

Do you have dental insurance? Yes / No **If yes**, Which fund? _____

MEDICAL HISTORY

Have you had any of the following? (Please tick)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Hepatitis A, B, C |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Heart Ailment | <input type="checkbox"/> Other Medical Problems |

Are you currently under medical care or taking any medication? Yes / No

If yes, name of medication: _____

Are you allergic to any drugs, medicines or latex? Yes / No

If yes, what? _____

Do you have an artificial hip, heart valve or other prosthetic implants? Yes / No

Name of doctor: _____ Phone No: _____

LADIES, are you pregnant? Yes / No

I have completed the above to the best of my knowledge and understand that failure to make a full disclosure may place me at undue medical risk. I also understand that I am fully responsible for the financial aspect of my dental treatment.

Signed: _____ Date: _____ Checked: _____