

# Confidential Medical History Form



---

*Please complete both pages*

Full Name .....

Address: .....  
.....  
.....

Date of Birth .....

Occupation .....

Telephone

Home: .....

Work: .....

Mobile: .....

Email Address: .....

Doctors Name and Address: .....  
.....  
.....

At Mike Allen's Dental Practice, we take great care with all the Personal Data we hold, to ensure that we comply with best professional practice and with the law. For a full copy of our Data Privacy Notice, please see our notices in the reception or ask the receptionist for a copy.

Please tick if you agree to Mike Allen's Dental Practice contacting you electronically

Date of First Completion .....

Patients Signature: .....

