



**2 Medical details** (all sections must be completed by the doctor in overall charge of the patient's treatment)

**Medical Practitioner's details:**

Name:

Address:

Qualifications:

Diagnosis:

Onset date when symptoms first noticed by patient: D   M   Y

When did the patient first see a doctor? D   M   Y

Details of treatment:

Details of operation:

Details of medication:

**Dental treatment**

Annual check	<input type="radio"/>	Preventive	<input type="radio"/>
Major restorative	<input type="radio"/>	Orthodontics	<input type="radio"/>
Accident / emergency treatment	<input type="radio"/>		

Details of treatment:

**Hospital dates:** Admission date: D   M   Y   Discharge date: D   M   Y

**Name and address of admitting hospital:** Reference number:

Name:

Address:

Telephone:

Fax:

Email:

**Medical practitioner's / dental surgeon's signature**

**Date**



