MaxMedical
We Listen. We serve. We care.

دبـــــي للتـــــأمـــين
DUBAI INSURANCE
CARE & COMMITMENT SINCE 1970

CONFIDENTIAL DENTAL HISTORY (MAXMEDICAL SHIELD)

IMPORTANT NOTES:

- Please answer the questionnaire completely and accurately in BLOCK CAPITALS.
- Kindly disclose all known medical conditions or suspected conditions and symptoms, whether or not professional advice has already been sought.
- Further information, if required, will need to be provided.
- Failure to disclose all the material facts may result to termination of cover or non-payment of claims.

1. APPLICANT

First Name			
Surname		Date of Birth (dd/mm/yyyy)	

2. PLEASE ANSWER ALL QUESTIONS WITH A 'YES' OR 'NO' AND PROVIDE COMPLETE DETAILS IF THE ANSWER IS 'YES'

1.	Have you had any dental treatment in the past?	☐ Yes ☐ No
2.	Have you had any pain or discomfort in the oral cavity?	☐ Yes ☐ No
3.	Do you suffer from periodontitis or any other gum diseases?	☐ Yes ☐ No
4.	Do you have any problem with regard to tooth alignment or gums forwardly set?	☐ Yes ☐ No
5.	Have all four wisdom teeth already erupted?	☐ Yes ☐ No
6.	Do you have missing teeth, crowns, inlays, implants, fillings or bridges? Please indicate in the dental tooth chart provided below.	☐ Yes ☐ No
7.	Are there any other conditions/facts relevant for disclosure?	☐ Yes ☐ No

3. DENTAL TOOTH CHART

UPPER RIGHT																UPPER LEFT
	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
LOWER RIGHT																LOWER LEFT

Legend

m missing teeth	**i** implants	**c** crowns	**b** bridges

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4. PLEASE PROVIDE DETAILS IF YOU HAVE ANSWERED 'YES' TO ANY OF THE QUESTIONS FROM 1 TO 7

Question number	Detailed description of illness, severity of symptoms and diagnosis	Treatment(s) received		Date	Current Status
		Inpatient	Outpatient		

5. LEGAL DECLARATION

I hereby:

1) declare that all the information given above is, to the best of my knowledge, true, complete and correct. I understand and accept that non-disclosure or misrepresentation of facts may lead to the refusal of claims or the cancellation of the MaxMedical Shield Contract.
2) authorise Dubai Insurance Company or their authorised representatives to obtain any medical information they require in connection with my membership application from any medical practitioner/authorised provider.
3) confirm that I have read and understood the terms, conditions, limitations and exclusions of the MaxMedical Shield Contract and agree that this proposal and declaration, or any written statement made by me with reference to this proposal, shall be the basis of the contract between the Dubai Insurance Company and me.

Signature

Place & Date

Please send this Confidential Dental History to: