NEW PATIENT REGISTRATION FORM

MR/MRS/MISS/MS/MASTER DATE OF BIRTH……....
SURNAME……..
FORENAME/S……....
ADDRESS…….…..……
……
CONTACT NO'S (Home, Work, Mobile……...……...……
OCCUPATION……..

IF YOU ARE ON BENEFITS PLEASE SHOW RECEPTION AT THE TIME OF REGISTRATION

GP SURGERY NAME AND FULL ADDRESS INC POSTCODE, TEL NO AND FAX.
(these are required in case of referral)….....**.....**
……
NHS NUMBER……

PLEASE CIRCLE YES/NO TO THE FOLLOWING AS APPROPRIATE:
Heart Trouble……..…Yes/No
Chest trouble/Asthma……Yes/No
Rheumatic Fever……Yes/No
Jaundice, Hepatitis……Yes/No
Diabetes……..…Yes/No
Tuberculosis, Epilepsy……...Yes/No
High Blood Pressure……..Yes/No
Allergies (eg. Penicillin)……Yes/No
Any Serious Illness or Operation……...Yes/No
Fainting or other attacks……...……Yes/No
Do you suffer from Head, Neck, Shoulder, or Back pain……..Yes/No
Migraine……Yes/No
Excessive Bleeding after a tooth extraction……...Yes/No
Please list all Medication (Tablets, Pills, Injections etc)**.....**…….....……Yes/No
……
Pregnant? Date Expected…… Yes/No
Consulted a Doctor, or been in Hospital within the last 2 years?**.....**Yes/No
If YES please give details……..
Date of last Dentist visit…….
Do you Smoke? How many a day……Yes/No
How did you find us?**.....**
Anything else you think the Dentist should know…….
Signature……..Date……..

Dentist Signature……
Ask your Dentist regarding Implants, Cosmetic Smile Makeovers, Laser Tooth Whitening and White Coloured Fillings.