NEW PATIENT REGISTRATION FORM

PLEASE NOTE NEW PATIENTS WILL BE ASKED TO PAY BEFORE THEY GO INTO THEIR APPOINTMENT

IF YOU RECEIVE BENEFIT PLEASE SHOW EVIDENCE AND INFORM RECEPTION

MR/MRS/MS/MISS/MASTER	DATE OF BIRTH:	
FIRST NAME:	SURNAME:	
ADDRESS:		
TEL:	MOB:	OCCUPATION:
GP SURGERY NAME & ADDRESS:		
TEL:	NHS NUMBER:	

CIRCLE YES OR NO TO THE FOLLOWING			
HEART PROBLEMS (e.g: Angina/Murmur/ Pacemaker/Surgery)		YES	NO
CHEST TROUBLE (e.g: Asthma/Bronchitis/Tuberculosis)		YES	NO
RHEUMATIC FEVER		YES	NO
JAUNDICE/HEPATITIS/HIV		YES	NO
DIABETES		YES	NO
EPILEPSY/FAINTING/BLACKOUTS		YES	NO
BLOOD PRESSURE - HIGH/LOW		YES	NO
PREGNANT?	DUE DATE:	YES	NO
HEAD, NECK, SHOULDER OR BACK PAIN/JOINT REPLACEMENT		YES	NO
MIGRAINE		YES	NO
EXCESSIVE BLEEDING		YES	NO
DO YOU SMOKE?		YES	NO
HAVE YOU HAD A SERIOUS ILLNESS/BEEN IN HOSPITAL IN THE LAST 2 YEARS - List below:		YES	NO
ALLERGIES (e.g: Penicillin)/**CARRY A WARNING CARD** - List below:		YES	NO
MEDICATION (e.g pills/injections) - List below or on the back:		YES	NO
ANTHING ELSE THE DENTIST SHOULD KNOW? -List below:		YES	NO
AS PART OF NEW DATA PROTECTION GUIDELINES ARE YOU HAPPY FOR US TO CONTACT YOU VIA PHONE/TEXT/EMAIL/LETTER		YES	NO

WE WILL CHECK AND VERIFY THE ABOVE DETAILS AT LEAST EVERY 6 MONTHS. PLEASE SIGN AND DATE.

PATIENT'S SIGNATURE	DATE	DENTIST'S SIGNATURE	DATE