New Patient Registration Form

This provides the dentist with important information required for your Dental treatment and Oral Health Care.

Patient name: ……..

Date of birth: …… Occupation: ……

NHS No: …… ***(You can get this from your GP. We need this to send referrals to other clinics if we do not have the number it will delay getting treatment at other clinics)***

Address:……
……

Home phone: …….. Mobile: ……

Email: ……..

Details of person to contact in an emergency.

Name: ……. Phone number: ……..

GP's Name & Address: ……..

1. Are you receiving any medical treatment at the present time? Yes/No

   Details: ……..

2. Are you taking any medication at the present time? Yes/No

   Details: ……

3. Have you experienced any allergies/unusual effects with any tablets, drugs, injections or anaesthetic? Yes/No

   Details: ……

4. Are you, or have you been, under the care of a doctor/hospital during the past two years? ***(Surgery, Clinics etc)*** Yes/No

   Reason: ……..

5. Have you ever had any of the following? If so, please tick as appropriate.

Rheumatic Fever		Diabetes		Hip Replacement		Heart Valve Replacement	
Severe Headaches		Cancer related disease		Kidney Trouble		Heart Trouble	
High Blood Pressure		Gastric Problems		Depressive Illness		Drug Dependence	
Hepatitis ***(Specify A, B,C)***		Asthma/ Chest Problems		Arthritis		Epilepsy	
Anaemia		CJD		Growth Hormone Treatments		Other	

6. Do you or have you ever suffered from excessive bleeding or bruising? Yes/No

7. Do you smoke or drink alcohol? If so what is your weekly intake? Yes/No

Tobacco: …… Alcohol Units: ……

8. If applicable, are you pregnant? If so, expected due date: …….. Yes/No

9. Are you HIV positive? Yes/No

DENTAL HISTORY

1. Do you have dental pain or a dental problem at present? Yes/No

Reason: ……

2. When did you have your last routine dental examination?

……..

Are you interested in any of the following?

- o Teeth whitening
- o Cosmetic work
- o Six Month Smiles
- o Invisalign
- o Improving the appearance of my smile

Signed: *Patient/Parent/Guardian:* …… Date: ……..

For new patients only

How did you hear about the practice? ***(Please tick)***

- o Facebook
- o Recommendation by family/ friend
- o Walking past in town
- o Word of mouth
- o NHS Choices
- o Google