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