NEW PATIENT REGISTRATION

Surname: ....Title: ……...............………….................................

First names: ……................………....……………………........Date of birth: ………………….........................

Address: ……………………………................………………………………………………...............................

………………………………...........…………………................. Post code:.…………………………................

Phone (home): ………………...…....……………….................... Mobile: ………………………......................

Phone (work): ………………………................…....…........Email: ………………………………......................

Occupation: ……...........…………………………………………………………………………….......................

How did you hear about this practice? ……………………………………..........…………….........................

How would you like us to contact you? Email / Text message / Telephone

Terms & Conditions

Prior to the commencement of treatment, patients will be given a written treatment plan outlining costs to be incurred. These costs are estimates based on the work we think will be necessary, but may be subject to change due to unforeseen developments. Prices quoted are valid for six months, after which time they may be subject to change. Any pricing changes will be discussed with you.

We request that patients pay for their treatments at the end of each appointment.

Please note that we reserve the right to charge a fee for appointments cancelled at short notice (within 48 hours, excluding weekends). This charge will be £150 per hour for dental appointments and £50 per hour for a hygiene appointment.

Appointments missed without notice will be charged at the full planned fee. We also reserve the right to charge interest in respect of accounts which remain unpaid for more that 30 days.

I understand and accept these terms and conditions.

Signature: ………………………………….………………………………...

Date: ………………………………………………………………………………..

MEDICAL HISTORY

Doctor's name: …………………………………………………………………...

Doctor's address: …………………………………………………………………...

…………………………………………………………........ Tel. number: ……………..

Previous dentist: …………………………………………………………………...

……………………………………………………………………………………...

Date of last dental visit: …………………………………………………………...

Please tick to indicate if you currently suffer from or have ever had any of the conditions listed below:

	Yes	No		Yes	No
A. Heart			**D. Allergies**		
Rheumatic fever			Penicillin		
High blood pressure			Hay fever		
Heart surgery			Anti-tetanus serum		
Pacemaker fitted			Eczema		
Heart murmur			Aspirin		
Thrombosis			Asthma		
Angina			Latex		
Other heart conditions			Other		
B. Chest			**E. Other**		
Bronchitis			Serious childhood illness		
Emphysema			Diabetes		
Pneumonia			Liver disease		
Chest surgery			Epilepsy		
Smoker			Cancer		
Cystic fibrosis			General anaesthetic		
Pleurisy			Hiatus hernia		
Other			Other		
C. Blood			**F. Bite**		
Bleeding			Pain in jaw joint		
Hepatitis B			Clicking		
HIV			Difficulty in opening jaw		
Anaemia			Night/day clenching/grinding		
Blood tests			Headaches/migraines		
Sickle cell			Neck/shoulder pains		
Haemophilia					
Other					

Are you pregnant?..

If you have ticked Yes to any of the above, please give further details: ....

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Please give details of any medication you are currently taking:..

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Do you carry any warning cards? If so, please give details. ....

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Do you require anti biotic cover? Yes/No ....

Any further relevant information: ....

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