inspire dental care

creating beautiful smiles

New Patient Registration Form

PLEASE MAKE SURE YOU COMPLETE EACH SECTION OF THIS FORM

Mr / Mrs / Ms / Miss / Mst / Other (please specify):		
Name:		D.O.B:
Address:		
Tel: Home:	Work:	Mob:
Email:	Occupation:	
N.I. number:	NHS number:	

Do you have Dental insurance?	☐ Yes	☐ No
Are you exempt from payment?	☐ Yes	☐ No
If yes, please state the exemption you hold, e.g. Maternity /Tax credit etc.:		
Do you have any special needs? E.g. Mobility etc.	☐ Yes	☐ No
If yes, please state how we can assist you:		
How did you hear about us?		

Doctors (GP) Details

Name:
Address:
Tel:

Information Sharing
Your information is normally used only by those working at the practice but there may be instances where we need to share it – for example, with:

- Your doctor, the hospital or community dental services or other health professionals caring for you
- NHS payment authorities
- The Department for Work and Pensions and its agencies, where you are claiming exemption or remission from NHS charges
- Private dental schemes of which you are a member.

We will only disclose your information on a need-to-know basis and will limit any information that we share to the minimum necessary.

Electronic Communications
Text messages are now an integral part of everyday life for many people and can improve and simplify the way we communicate with our patients. However, we will only send you texts if you give us your permission to do so.

☐ I consent to receiving text messages and understand that I can opt out from receiving these communications at any time by speaking to a receptionist or to my dentist and asking them to amend my records.

Radiography/Photography
☐ I consent to have radiographs and clinical photographs taken of my teeth.

Name of the person completing this form: _____

Signed: _____ Date: _____

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MEDICAL HISTORY

Do you smoke? If yes please state how many per day.	
Do you drink alcohol? If yes please state approx units per week.	
Have you had Rheumatic Fever or Chorea?	
Do you have Chronic Bronchitis, Asthma or any other Respiratory disease?	
Do you or anyone in your family have Diabetes?	
Do you suffer from Epilepsy, blackouts, giddiness or fainting?	
Do you have Hepatitis, Jaundice, Liver or Kidney Disease?	
Do you suffer from Excessive bleeding and/or bleeding disorder?	
Do you have High Blood Pressure or Angina?	
Do you suffer from Heart Disease or had a heart attack or any other related complaints?	
Do you have Arthritis?	
Have you ever undergone a joint replacement?	
Have you had Steroid Therapy in the last two years?	
Do you suffer from Herpes or Cold Sores?	
Are you H.I.V. positive?	
Have you ever undergone blood tests? If so why?	
Have you ever had a blood donation refused? If yes why?	
Have you had any treatment that may affect your dental care?	
Do you have any serious or related medical condition?	
Are you taking any medication at present? If you take multiple medications, please list overleaf.	
Are you allergic to any medicines, tablets or materials?	
Have you ever had an allergic reaction to Local or General anaesthetic?	
Do you have any other known allergies?	
Are you pregnant? Please specify due date.	
Are you a mother of a child under 12-months old?	

It is very important that you inform us of any changes to the above

Date	Patient signature	Dentist signature

Date	Patient signature	Dentist signature