scatrafalgar
servicing all your dental needs

Confidential Practice Registration Form

Personal Details
Title:
Surname:
First name:
Date of birth:
Male/ Female:
Ethnicity:
Height:
Weight:
NHS Number:

Contact Details
Address:
Post code:
Telephone Home:
Telephone Mobile:
Email address:

Emergency Contact details
Name:
Relation:
Contact number:

Previous Dental Background
Last Dental visit:
Previous Practice Name:
Previous Dentist Name:
How did you hear about the practice?

(Tick)	Are interested in the following types of dental treatment? Please give detail if necessary
	Crown or bridgework?
	Dentures?
	Seeing the dental hygienist?
	Improving gum health?
	Dental implants?
	Tooth Whitening?
	Changing the appearance of your teeth?
	Other (please specify)

(Tick)	Are you currently? Please give detail if necessary
	Unhappy with any dental treatment received in the past?
	Are there any dental problems which concern you now?
	Do you have any dental pain or sensitivity?
	Do your gums bleed?
	Are any of your teeth mobile?
	Do you have problems with your jaw joint?

Medical Questionnaire

In order for us to provide you with the best possible care, and to ensure that you are treated safely, it is imperative that you answer the following questions to the best of your knowledge. This form must be filled in carefully and appropriately and all questions must be answered.

GP details
Doctor's name:
Doctor's address:
Doctors Telephone:
NHS Number:

Are you currently?	**Y**	**N**	**Please give detail**
Receiving treatment from a Doctor or hospital?			
Carrying a medical warning card?			
Fitted with a pacemaker?			
Pregnant? If so, are you breastfeeding?			
Taking steroids, or have done in the past 2 yrs?			

Do you suffer from/ have you suffered from?	**Y**	**N**	**Please give detail**
Allergies to any food, substance or medicine?			
Hay fever or eczema?			
Bronchitis, asthma, any other chest condition?			
Fainting, giddiness, blackouts, or epilepsy?			
Heart problems, angina, blood pressure?			
Stroke?			
Diabetes?			
Arthritis?			
Liver disease or kidney disease?			
Rheumatic fever or chorea?			
Any other serious illness?			
Hepatitis?			
HIV or AIDS?			
Any other infectious disease?			

Have you ever had?	**Y**	**N**	**Please give detail**
Blood refused by the blood transfusion service?			
A bad reaction to general or local anaesthetic?			
A joint replacement or other implant?			
Treatment that required you to be in hospital?			
Heart surgery?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			

Alcohol and tobacco	Y	N	Please give detail
Do you drink alcohol? If so, How many Units per week?			
Do you smoke or chew tobacco products? If so, how many times per day?			

Do you suffer or have you suffered in the past from any other condition not listed on this form?

Please give any other details which your dentist might need to know about

Please list and prescribed medicines you are taking below:

Declaration:

Completed by Self/Guardian; I hereby apply to become a patient of Trafalgar Dental Practice. I give my consent that any information given may be stored as computerised or manual data. This data may be used for the purposes of monitoring the makeup of the workforce and our customer base and may be seen by senior managers or officers of the company involved in the monitoring of such data. ‘’The information you supply will be held and used by the SCA Group, including its subsidiary companies, for administrative and communication purposes within the terms of the Data Protection Act 1998. We will never supply it to third parties.”

Name:

Sign:

Date:

Please advise a member of the team if you have any special requirements that the practice should be aware of to ensure that our services are appropriate to your needs.