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| ***Waddesdon Dental*** | ***5 High Street******Waddesdon******HP18 0JB******01296 655577****smile@waddesdondental.co.uk**www.waddesdondental.co.uk* |

**Patient Registration Form**

Please spend a few minutes completing this confidential registration form and medical history. This information will enable us to provide you with an efficient service and ensure that any dental treatment does not interfere with your current medical status. All details will remain confidential and will only be seen by those directly involved in your treatment. MK Dental Spa is registered with the Information Commissioner’s Office for data protection.

Title: Mr / Mrs / Ms / Miss / Mst / Dr / Rev / ……………………………………………

First name: ………………………………………... Surname: …………………………………………………… Date of Birth:.………..………...………….

Home Tel: ……….……………………………..………….….……….... Mobile Tel: ………….…..………………………………………………….………………

Email: …………………………………………………….…………………….……… Work Tel: …………………………..…………….….…………..……………..

Preferred method of contact: Text / Mobile phone / Home phone / Work phone / Email

Home Address. ………………………………………………………………………………………………..……………………………………………………………....

…………………………………………………………………………………………………………………………………………………………………………………………..

Details of person to contact in an emergency:

Name: ………………….………………… Relation to patient ……..….……………....... Phone Number ……………..……..…………………………

**About your dental health**

When did you last visit a dentist? ……………………….. months ago/ years ago

Are you having any discomfort with your teeth? Yes / No ………………………………………………….….

Does anything about the appearance of your teeth concern you? Yes / No ………………………………………………………

Do your gums bleed when brushing or flossing? Yes / No ……………………………………………………..

Do you get a bad taste in your mouth or suffer from bad breath? Yes / No ……………………………………………………..

Are your teeth stained or becoming darker? Yes / No ……………………………………………………..

Do you grind your teeth at night or when stressed? Yes / No ……………………………………………..……..

Are you anxious about dental treatment? Yes / No …………………………………………………….

How did you hear about us? Sign / Website / Google / Advert / Offer / Other ………………………………………………….

Or, I was recommended by ……………………………………………………………..…… We will send them a voucher to say “thank you”

**Confidential Medical History**

GP Practice: ………………………………….. GP Name: …………………………………….…….. Phone Number: ………………..………………………

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

 □ Rheumatic Fever □ Epilepsy □ Heart Trouble □ Bronchitis or Chest Problems

 □ High Blood Pressure □ Kidney Trouble □ Asthma □ Gastric Problems

 □ Cold Sores □ Diabetes □ Arthritis □ Hepatitis – Specify type A, B, C

 □ Depressive Illness □ Anaemia □ Severe Headaches □ Drug Dependence

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

3. Have you been a patient in hospital during the past two years? Yes / No

4. Have you taken any medicine tablets, capsules or drugs during the past two years? Yes / No

*Please list any prescribed medicines…………………………………………………………………………………………………………………………………..*

………………………………………………………………………………………………………………………………………………………………………………………….

5. Are you allergic to anything? If yes what? …………………………………………………………………….….. Yes / No

6. Are you, or have you been, under the care of a doctor during the past two years? Yes / No

*Please give details* ………………………………………………………………………………………………………………………………………………………….

7. Have you had any prosthetic surgery? (e.g. Heart Valve or Hip Replacement) Yes / No

8. Women - Are you pregnant? If so, how many months: …………………………………… Yes / No

9. Are you HIV positive or at risk to HIV exposure? Yes / No

10. Have you travelled to West Africa within the last 3 weeks? Yes / No

11. Do you smoke? Yes / No

 🗆 Cigarettes 🗆 Pipe 🗆 Cigar Average daily amount: …………………….

12. How many units of alcohol do you consumer per week? .................................

Any other medical information /details ……………………………………..………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………………………………………..

Patient/Guardian Signature: ……………………………………………………………… Date: ………………………………………..

Guardian’s relationship to patient: ……………………………………………………..

**Payment:** We are pleased to accept the following methods of payment:

 Cash, Debit & Credit Card (not American Express), Cheque, Finance Options including 0% (Please ask for details)

**Cancellation Policy:**  In order to provide you with an efficient and reliable service we require:

**2 working days’ notice** to cancel or rearrange a routine dental or hygiene appointment and **seven working days’ notice**

for routine visits over 60 minutes. We also require **seven working days’ notice** to cancel or to rearrange all specialist

appointments. Charges will apply for cancellations or re-bookings made after these periods.