New Patient Registration

All patient information will be treated confidentially, and is solely for the use of the dental practice.

Surname: ____

First Name(s): _____________________________________

Title: Dr / Mr / Mrs / Miss / Ms

Date of Birth: _____________________

Occupation: ___________________________________

Home Address: ____

____

____

Home Phone No. ____________________

Mobile Phone Number: __________________________

Work Phone No. ____________________

Email Address: _________________________________

- Do you give Shelley Manor Dental permission to send you appointment confirmation messages and appointment reminders using the given mobile number and email address? **Yes / No**
- If you do not possess a mobile telephone, do you give Shelley Manor Dental permission to send you SMS messages via your landline telephone? **Yes / No**

How did you find out about Shelley Manor Dental?

1) Referred by another patient ☐ If so, what is the patient's name? _________________________

2) Referred by a GP from Shelley Manor Medical Centre ☐ If so, which GP? _________________________

3) Leaflet drop ☐

4) Saw the outdoor sign ☐

5) Shelley Manor website ☐

6) Other (please specify) ☐ ____

By signing this form I consent to a Dental Examination

Signed: Patient/Parent/Guardian:_______________________________ Date:____________________

Confidential Medical History Questionnaire

This provides the dentist with important information required for your dental treatment.

Name: ___________________________________ Date of Birth: __________________________

Emergency Contact: Name ______________________________ Phone No.______________________

Name of your medical doctor (GP): ______________________________

Surgery name: ______________________________ Phone number (if known): ____________________

Medical History

1. Are you receiving any medical treatment at the present time? Yes / No
   Details: ____
2. Have you been a patient in hospital during the past two years? Yes / No
   Reason: ____
3. Have you taken any medicine tablets, capsules or drugs during the past two years? Yes / No
   Details: ____
4. Have you experienced any allergies or unusual effects from: latex/ nickel/antibiotics/local anesthetics/other tablets/drugs/injections? Yes / No
   Details: ____
5. Are you, or have you been, under the care of a doctor during the past two years? Yes / No
   Reason: ____
6. Have you ever had any of the following? If so, please tick as appropriate.

☐ Rheumatic Fever	☐ Epilepsy
☐ Heart Trouble	☐ Anemia
☐ High Blood Pressure	☐ Diabetes
☐ Asthma	☐ Kidney Trouble
☐ Arthritis	☐ Gastric Problems
☐ Hepatitis - Specify type A, B, C	☐ Cold Sores
☐ Bronchitis or Chest Problems	☐ Depressive Illness
☐ Severe Headaches	☐ Drug Dependence

7. Have you had any prosthetic surgery? (E.g. Heart Valve or Hip Replacement) Yes / No
   Details: ____
8. Are you pregnant? If so, how many months: _____________________ Yes / No
9. Are you HIV positive? Yes / No
10. Are you at risk to HIV exposure? Yes / No

Dental History

1. Name of Last Dentist: ____
2. Approximate date of last dental visit:
   Details: ____
3. Do you have dental pain or a dental problem at present? Yes / No
   Details: ____
4. Have you ever experienced excessive bleeding or bruising from dental treatment? Yes/No
5. Do you become anxious or uncomfortable when you are having dental treatment? Yes / No

Signed: Patient/Parent/Guardian ______________________________________ Date: ____________

By signing this form I consent to a Dental Examination