The High Street Dental Practice

New Patient - Getting To Know Your Needs

At The High Street Dental Practice, we aim to ensure that you are satisfied with your dental treatment so please could you take a few moments to complete this form and bring it with you to your consultation. All information is kept strictly confidential.

NAME AND TITLE		**DATE OF BIRTH**	
OCCUPATION		**NHS NUMBER**	
ADDRESS	POSTCODE:		
MOBILE NUMBER		**LANDLINE**	
EMAIL ADDRESS			
WHEN DID YOU LAST VISIT A DENTIST?			
SCHOOL (if under 18)	SCHOOL NAME:		
NEXT OF KIN	NAME AND TITLE: RELATIONSHIP TO YOU: TELEPHONE NUMBER: ADDRESS:		

IF YOU WERE REFFERED PLEASE CIRCLE APPRORPIATLY AND PROVIDE DETAILS

REFERRER: DENTIST / SOLICITOR / FRIEND / RELATIVE

DETAILS:

HOW DID YOU HEAR ABOUT US?	INSTAGRAM		GOOGLE SEARCH	
	FACEBOOK		PAVEMENT A-BOARD	
	RECOMMENDED		OTHER (PLEASE SPECIFY)	
	RETURNING PATIENT			

Please turn over

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Confidential Medical History

	YES	NO	DETAILS
Are you taking any medicines, tablets or having injections? Please give full details			
Do you have or had in the past HIV, hepatitis or infections from any other disease?			
Do you have any of the following:			
Heart trouble such as high blood pressure?			
Chest trouble such as asthma?			
Allergies?			
Epilepsy?			
Subject to fainting?			
Diabetes?			
Jaundice?			
Haemophilia, or subject to excessive bleeding?			
Have you had any operations or been in hospital for any reason?			
Have you visited the doctor for any reason?			
Are you pregnant?			
Do you smoke? If yes, how many per day?			
Does your alcohol intake exceed 21 units/14 units per week? A unit is half a pint of lager, a single measure of spirits or a single glass of wine			
DOCTOR GP PRACTICE: GP NAME:			

Name and title:

Signature (please circle: individual/parent/guardian):

Date:

Dentist signature:

Date:

Communication Consent Form

We process personal data for the purposes of providing optimum dental healthcare, sending important updates to you about your appointments and care provider, providing you with news about treatments and what is happening at the practice and informing you about our services. You can withdraw your consents at any time.

Appointments and Treatments

		Yes	No
I am happy for the Practice to contact me about my **appointment and/ or treatment.** This includes receiving appointment reminders.		☐	☐
The Practice can discuss my **appointment** with the following person/s: Name: Email:	Phone: Name: Email: Phone:		
In accordance with the Mental Capacity Act 2005, I authorise the below person to be the decision maker on my behalf regarding any treatment I may receive: Name: Email:	Relationship: Phone:	Yes ☐	No ☐

Practice Updates

	Yes	No
I would like to receive details of new treatments and services at the Practice.	☐	☐

Patients Name (Please print):

Patients Signature:

Date:

Your personal information is never passed to third parties for their own marketing, sales, or promotions. We have strict arrangements with companies who process your data on our behalf.
You can withdraw your consents at any time by contacting the Practice on 01249 477001 or emailing info@thehsdp.co.uk.
For further details about how we process your personal information and your data rights, please see our Privacy Notice on our website, www.thehighstreetdentalpractice.co.uk, or contact us at info@thehsdp.co.uk or 01249 47001 to request a copy of it.