REGISTRATION FORM

Title	Surname	First Names
Address		

Date of Birth	Male/Female	Tel No Home
Tel Mobile		Tel No Work
Email Address		Occupation
How long since last received dental treatment		Referral source
Your Doctor's name and address		

INSURANCE INFORMATION

Do you have any Private Dental Insurance?
Name of Insurance Company

ABOUT YOU

Why did you choose our Practice?		Is another member of your family or a relative a patient of ours?	
When was your last visit to a dentist?		When was the last time you had complete dental x-rays taken?	
Have you ever had any teeth removed?		How long have these teeth been missing?	
Have these teeth been replaced?			
How have these teeth been replaced:	Bridge	Denture	Implant
Briefly describe the nature of your dental problems?			
Person to contact in emergency?	Name & Relationship		
	Tel No	Mobile No:	

PAYMENT OPTIONS

1. Cash and personal cheques are accepted at the time of your treatment being provided.	3. MASTERCARD/VISA/ACCESS/SWITCH – Please complete the attached authorisation form.
2. Payments in full for the entire treatment plan of £1,500+ will attract a 5% courtesy reduction.	4. STANDING ORDER PROGRAMME – is available with prior arrangement. Please ask for further details.
If you have full dental insurance, we want you to be able to receive the full benefit of it. Our staff can assist you in completing your insurance claim-form.	

CONSENT CONFIRMATION

I authorise the dentist to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above. I further authorise and consent that the dentist chooses and employs such assistance, as she deems fit. I also understand that prior to treatment commencing a full explanation of the procedure(s) involved will be given by the dentist and her staff. I agree to pay for all services rendered by this dental practice.
Completer by SELF – Parent - Guardian (Please give name if not as above)

Signed:	Date: