

**New Patient Form – Private Adult patients**

Please provide the following information about your personal details. We will hold this information on our records.

All information given will be held in confidence.

|  |  |
| --- | --- |
| Title (please circle) | Mr Mrs Miss Mst Ms Other: |
| Forename(s) |  |
| Surname |  |
| Date of Birth |  |
| Email Address (please print clearly) |  |
| Full Postal Address | Post Code |
| Telephone number (s) |   |
| Do you require a downstairs surgery? (please circle)  | Yes No  |

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| --- |
| Please tick if you would be happy to receive information about our services, products and any information relating to the our practice we feel may be of interest to you. TELEPHONE ☐ EMAIL ☐ TEXT ☐  |

|  |
| --- |
| Next of Kin Details  |
| Title (please circle) | Mr Mrs Miss Mst Ms Other: |
| First name  |  |
| Surname |  |
| Contact Number |  |
| Relationship to you |  |
| Address | Post Code |

|  |  |
| --- | --- |
| When did you last visit a dentist? |  |
| Doctors Name and Address |  |
| Doctors telephone  |  |

**Please send completed forms to the practice manager at** **laura.hendry4@nhs.net**

***Thank You***

***Safety Information***

***Our dental chairs have a safe working limit of 21 stone/135 Kgs. If you exceed this weight limit, unfortunately we will not be able to see you at the practice.***