

NEW PATIENT QUESTIONNAIRE

NAME

TITLE

ADDRESS

DATE OF BIRTH

TELEPHONE NUMBER DAYTIME:

EVENING:

MOBILE:

EMAIL:

DOCTOR'S NAME AND ADDRESS:

PREVIOUS DENTIST:

Are you exempt from NHS dental charges? (please give reasons for exemption)*

Would you like a form to claim full or part remission of NHS charges on the grounds of low income?*

YES/NO

Would you like to receive your dental care under the NHS , private contract or a private dental plan ?

Please indicate if you are interested in the following types of dental treatment

- | | |
|--|---|
| <input type="checkbox"/> Crown or bridgework | <input type="checkbox"/> Improving gum health |
| <input type="checkbox"/> Seeing the dental hygienist | <input type="checkbox"/> Dentures |
| <input type="checkbox"/> Dental implants | <input type="checkbox"/> Fissure sealants |
| <input type="checkbox"/> Tooth Whitening | |

Other please specify.....

How did you hear about the practice?

Please tell the dentist if you have a disability that the practice should be aware of to ensure that our services are convenient to your needs