New Patient Registration Form (Child)

Rowcroft Dental & Implant Centre

This form is designed to aid the dentist in formulating the most effective treatment regime for you as an individual please answer the questions as fully but concisely as possible

Name:

Date of Birth

Address

All information given by you on this form is confidential to the practice. Under no circumstances will details be provided to a third party.

Home Telephone

Mobile

e-mail

School

Name of Person with Parental Responsibility

Primary Carer (if Different)

Most convenient times for appointments (please tick)

	Mon	Tues	Wed	Thurs	Fri
AM					
PM					

Previous Dental Surgeon

Reason for leaving

When was your last visit to a dentist?

How frequently do you normally attend the dentist?

What treatment did you have at your last visit?

Have you ever been treated for Gum disease or pyeria? YES NO

Do you have any Anxieties about dental treatment? Please give details

Do you have any problems or concerns with your teeth at the moment? Please give details

Any other comments of relevance to your dental treatment.