Welcome to **High Barnet Dental Care**.

Please complete the following details to process your registration.

Mr **Mrs** **Ms** **Miss** **Dr** **Other**

First Name*…….....**Surname/Family Name*** …….....

Date of Birth*…….**Occupation**……..

Address*……...

Town/City……. **Postcode***……..

Home Telephone*…… **Mobile*** ……...

Email Address*……

National Insurance Number.....**NHS Number**.....

Next of Kin*…… **Contact Details*……**

Do you want to be Registered as a	**PRIVATE**	**NHS**

If NHS, are you currently on any State Benefits (Please Specify)……

What is your ethnic group? Please choose ONE selection from the list to indicate your ethnic group:

[ ] White British [ ] White Irish other [ ] White Background [ ] White& Black Caribbean [ ] White &Black African

[ ] White &Asian [ ] Other mixed background [ ] Asian or Asian British Indian [ ] Asian or Asian British Pakistani

[ ] Asian or Asian British Bangladeshi [} Other Asian background [ ] Black or Black British Caribbean

[ ] Black British African [ ] Other Black background [ ] Chinese [ ] Any other ethnic group [ ] Patient declined

Patients Consent to Registration

I wish to register as a patient with a dentist at High Barnet Dental Care. I understand and agree to the following:-

-That the agreement by which I will be given dental treatment (my Treatment Plan) is an agreement between the **Dentist** and myself, and is not an agreement to which High Barnet Dental Care is a part.
-That, under my treatment plan, my treatment will be paid for in total by the last visit.
-That, under my treatment plan, I may be required to pay in advance for certain items of treatment.
-That, if I fail to attend 2 NHS appointments then I will not be eligible for further treatment on the NHS. (NHS Regulations).
-It remains the full responsibility of each patient to remember and to attend their appointments as scheduled. High Barnet Dental Care will not accept any responsibility in anyway for failed dental appointments.
-That NHS patients may be put on the NHS waiting List and treatment will be carried out when possible. Alternatives to this may be to have the treatment done **Independently** or **Privately** where treatment will be offered at the next earliest appointment.
-That a 50% Non Refundable deposit will be taken to book all Hygiene appointments.
-I consent to, if necessary, clinical photograph to be taken and saved in my records.
-NHS emergency times are between 10am-11am Mon-Fri. Any emergency seen at any other time will be on a private basis only.
-Please note all NHS courses of treatment will be claimed within 2 months of last appointment if no further appointments are booked and any outstanding work will be started on a new course of treatment with a new charge being generated.

I confirm that I have read and understand the terms and conditions mentioned above.

Signed ……..... Date…….

HBDC

Medical History Update Form

Name:.....

Are you:		
Receiving treatment from a Doctor, Hospital or any Other Clinic?	□ **YES**	□ **NO**
Taking any Medicines or Tablets (Creams, Ointments or Injections)?	□ **YES**	□ **NO**
Taking or have taken Steroids in the last 2 years?	□ **YES**	□ **NO**
Pregnant?	□ **YES**	□ **NO**

Have you:		
Had Rheumatic Fever or Chorea?	□**YES**	□ **NO**
Had Jaundice, Liver, Kidney Disease or Hepatitis?	□ **YES**	□ **NO**
Ever had Heart Murmur, Angina, Blood Pressure Problems or Heart Attack?	□ **YES**	□ **NO**
Had any Blood Tests? If so what for?	□ **YES**	□ **NO**
Had a Reaction to Local or General Anaesthetic?	□ **YES**	□ **NO**
Had a Joint Replacement?	□ **YES**	□ **NO**
Been Hospitalised? If so what for?	□ **YES**	□ **NO**

Do you:

Suffer from any Allergies? □ Latex □ Disinfectant Mouth Wash □ Any Other Dental Related Products

□ Antibiotics (Please Specify): □ **Penicillin** □ **Erythromycin** □ **Metronidazole** □ **Other……**

Have arthritis or Joint Problems?	□ **YES**	□ **NO**
Have a Pacemaker or have any Heart surgery?	□ **YES**	□ **NO**
Suffer from Hayfever, Eczema?	□ **YES**	□ **NO**
Suffer from Bronchitis, Asthma or any other Chest Conditions?	□ **YES**	□ **NO**
Have Fainting Attacks Blackouts or Epilepsy?	□ **YES**	□ **NO**
Have Diabetes? Or Anyone in the family?	□ **YES**	□ **NO**
Have any Bleeding Disorders?	□ **YES**	□ **NO**
Carry any Warning Cards?	□ **YES**	□ **NO**
Ever get Cold sores?	□ **YES**	□ **NO**
Smoke?	□ **YES**	□ **NO**
If so approximately how many cigarettes a day?	1-10	11-30 30+
Do you drink alcohol?	□ **YES**	□ **NO**

If so how many units a week? ……

Pleas list all the medications you are taking at present:

I confirm that my medical details have been updated at HBDC on the following dates:

Signature.....

Date.....