CARE *PLUS*

New Patient Registration Form

Our Care Plus scheme is designed to provide you and your family with quality dental care at affordable prices.

As a Care Plus patient you will have the choice of which participating dentist you would like to see.

You will be asked to pay an initial consultation fee at the time of booking; this is to secure your first appointment time. We reserve the right to retain this fee in the event of late cancellation or failure to attend.

All future treatment costs will be explained to you by the dentist prior to booking your next appointment.

We will ask for 50% of the total treatment cost at the time of booking your next appointment. We reserve the right to retain this fee in the event of late cancellation or failure to attend.

We accept payment by cash, debit card or credit card. You can also apply to pay for treatment using our 0% interest monthly payment service.

There will be no charge for changing your appointment provided that we are given at least 24 hours notice.

☐ **I understand and accept the above terms and conditions.**

☐ **I understand and accept that my deposit may be retained by the practice in the event of late cancellation or a failure to attend a booked appointment.**

☐ **I understand and agree to The Parade Patient Agreement which all registered patients of the practice are subject to. View the agreement at the practice reception or www.theparadedental.co.uk/patientagreement**

Title: _____ Full name: _____

Date of birth: _____ Gender: _____

Address: _____ Postcode: _____

Phone number: _____ Email address: _____

Signed: _____ Date: _____

Confidential Medical History Form

THE PARADE DENTAL

Title:	Name:	
DOB:	Occupation:	
Address Postcode:		
Home Tel No.	Mobile No.	Work No.
E-mail Address:		
How long since you last received dental treatment?		
Are you pregnant/possibly pregnant?	Yes/No	

Doctor's Details	In event of emergency, please contact
Name	Name
Address	Tel No.
	Relationship to you

Are you:	Yes	No	Give details and list medications
Receiving treatment from a doctor, hospital or clinic?			
Taking any medicines (Tablets, Injections, Inhalers, Bisphosphonates)?			
Taking or have you taken steroids in the last two years?			
Allergic to any medicines, foods or materials?			
Have you:	**Yes**	**No**	**Give details and list medications**
Had rheumatic fever or chorea (St Vitus Dance)? Heart murmur or heart problem?			
Angina, Blood pressure, Heart attack, Stroke?			
A pacemaker, or have you had any form of heart surgery?			
Asthma, Bronchitis or other chest condition?			
Hay fever, eczema, or any other allergy?			
Fainting attacks, giddiness, blackouts or Epilepsy?			
Had Jaundice, Liver or Kidney disease?			
Ever had HIV, Hepatitis B or Hepatitis C?			
Have Diabetes or does anyone in your family?			
Arthritis, Bone or Joint disease?			
Bruising or persistent bleeding after injury, tooth extraction or surgery?			
Had a bad reaction to a general or local anaesthetic?			
Been hospitalised? If "yes" what for and when?			
Carry a medical warning card?			
Alcohol and Tobacco Use	**Yes**	**No**	**Number per day**
Do you currently or did you smoke tobacco products?			Now In past
How many units of alcohol do you drink? (A unit = half pint lager/single measure of spirits/single glass of wine)			Units per week
Are there any other aspects concerning your health or issues that you think the dentist should know about?			

Signature:_____ Completed by: Self/ Parent/ Guardian Date:_____