

New patients' registration form

Please fill out the following form to help us contact you. If we are aware of your particular concerns we can ensure that there is time to discuss them at your appointment. Please bring it with you when you next visit the surgery, or send it to our postal address.

Identity information

Title	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Dr <input type="checkbox"/>	Miss <input type="checkbox"/>	Ms <input type="checkbox"/>
Forenames	<input type="text"/>				
Surname	<input type="text"/>				
Gender	Male <input type="checkbox"/>		Female <input type="checkbox"/>		
Date of birth	<input type="text"/>				

Contact details

Your address	<input type="text"/>				
Your postcode	<input type="text"/>				
Daytime telephone	<input type="text"/>		Evening telephone	<input type="text"/>	
Mobile phone	<input type="text"/>				
Email address	<input type="text"/>				
How do you prefer to be contacted?	Email <input type="checkbox"/>	Post <input type="checkbox"/>	Telephone <input type="checkbox"/>		

How can we help you?	Please provide me with information <input type="checkbox"/>
	Help me to register and arrange an initial consultation <input type="checkbox"/>
	Make an appointment for me <input type="checkbox"/>

Appointments are available weekdays, what time suits you best?	8 am – 10 am <input type="checkbox"/>	10 am – noon <input type="checkbox"/>	noon – 2 pm <input type="checkbox"/>
	2 pm – 4 pm <input type="checkbox"/>	4 pm – 6 pm <input type="checkbox"/>	6 pm – 8 pm Thursdays only <input type="checkbox"/>

Your needs

Do you require disabled car parking for appointments?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you require wheelchair access?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you find stairs difficult?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have other special requirements?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Your concerns

Are you in any pain?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are your teeth sensitive?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do your gums bleed when you brush your teeth?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you experience frequent headaches, pain or stiff neck?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are you concerned with the appearance of your teeth and smile?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are you worried by the colour of your teeth, crowns or fillings?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are you worried by gaps that show between your teeth?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are you worried that your breath smells?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do your dentures feel uncomfortable?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are you concerned about the cost of treatment?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

How did you hear about us?	Yellow pages	<input type="checkbox"/>	Internet	<input type="checkbox"/>	From a friend	<input type="checkbox"/>
	Professional referral	<input type="checkbox"/>	Advertisement	<input type="checkbox"/>	Other	<input type="checkbox"/>
This form has been completed by	Self	<input type="checkbox"/>	Parent	<input type="checkbox"/>	Guardian	<input type="checkbox"/>

Thank you for filling out the new patients registration form. Please bring it with you when you next visit the surgery, or send it to our postal address at:

Granta Dental, The Old Coach House, 53 Newnham Road, Cambridge, CB3 9EY