Accessible Orthodontics
MAKING SMILES STRAIGHT FOR ADULTS & CHILDREN

NEW PATIENT FORM

Welcome to Accessible Orthodontics. Please take a moment to complete this **New Patient Form** and the other attached Forms.

If you have any questions or wish to provide us with additional information, please speak with our staff. Thank you for your time.

Personal Information

Title (*please CIRCLE one*)	MR / MASTER **or** MRS / MS / MISS	**NHS #**
First Name		
Last Name		
Date of Birth	(Day/month/year) ……. / ……. / …….	***Sex:** (tick one)* ☐ F ☐ M
Address		
Town/City		
County & P/code		P/Code
Phone - Wk		
Phone - other	Home	Mob
Email Address		

Our services include reminding Patients of Appointments – by letter or sms to your nominated address / mobile number ☐ **YES,** I want this free service **(tick as applicable)**

Treating Dentist	Dr.	Phone
Dentist Address		P/Code

Is English your preferred first Language? ☐ Y ☐ N

If NO, Please Specify

How did you hear about us? (*please TICK one*)

☐ A referral/Your Dentist ☐ Advertisement ☐ Directory Listing ☐ Family of friend in treatment

☐ Your school or university ☐ Website www.accessible-orthodontics.co.uk

☐ Other:

I am (***DELETE as applicable***) the Patient / Parent or Guardian of the Patient.

I confirm that I will inform you promptly of any changes to any information about the Patient. I understand that **Accessible Orthodontics** may, at any time, need to arrange for a different clinician to oversee Treatment

✕…….. DATE …….. / …….. / ……..

(NAME) ……..……...

Office Use Only (use P Tick)			
Entered Case Note		Med Hx Form	
Entered MKT Table		XCHKd: CN & D/b	&