Recording Forms

FORM 1 - PATIENT'S PERSONAL DETAILS

CHI Number: _____

Title

- ◯ Mr
- ◯ Mrs
- ◯ Ms
- ◯ Miss
- ◯ Other

Permanent Address

Postcode: _____ **Surname:** _____

Forename: _____

Sex

◯ Male ◯ Female

Date of Birth: _____ dd / mm / yyyy **Email Address:** _____

Contact Phone No.: _____ **Family Name at Birth:** _____

Occupation: _____ **If retired, previous occupation:** _____

Doctor's Name: _____ **Doctor's Address:** _____

Doctor's Phone No.: _____

Ethnicity

- ◯ White
- ◯ Black, Black British, Black Scottish
- ◯ Asian, Asian British, Asian Scottish
- ◯ Mixed
- ◯ Other ethnic background

If mixed is selected, please state: _____

If other ethnic background, please state:

If you are filling in this form on behalf of the patient, please also enter YOUR OWN details below

Surname: _____ **Forename:** _____

Relationship to Patient

◯ Parent/Guardian ◯ Carer ◯ Other family member ◯ Other

Address

Postcode: _____ **Phone No.:** _____

Additional Information

Signature of Patient, Parent or Carer
Date: _____ dd / mm / yyyy

FORM 2 - SOCIAL AND DENTAL HISTORY

CHI Number: _____ Surname: _____

Forename: _____

When did you last see a dentist?

- ◯ Within the past 6 months
- ◯ 6 months to 1 year ago
- ◯ 1 - 2 years ago
- ◯ More than 2 years ago
- ◯ Never been to the dentist

Have you received any dental treatment under local anaesthetic (injection in the gum)? If yes, please note whether it caused you any problems

◯ Yes ◯ No ◯ Unsure

Further details