



Nightingale Dental

IMPLANT  
CENTRE

Mr/Mrs/Miss/Ms/Master **This is only a temporary registration, if any treatment is required, we will do this and then you will need to find an alternative practice.**

First Name: .....

Surname: .....

Date of Birth: .....

**Full Address:**.....

**County**.....

**PostCode**.....

NHS number (you can get this from GP).....

We need this to send referrals to other clinics if we do not have the NHS number it will delay getting treatment at other clinics

Doctor Surgery Name & Contact Number

.....

Your Email: .....

Home telephone: .....

Mobile: .....

Work: .....

When did you last visit a Dentist: .....

How did you hear about us: .....

Is there anything you are concerned about: .....

Please indicate if you are interested in any of the following types of treatment	
Filling	
Dentures	
Crown or Bridge	
Improving gum health /hygienist	
Tooth whitening /cosmetic/Invisalign	
Dental Implants	
Exam only	

## Nightingale Dental & Implant Centre

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