QualityCare Dental Group Limited
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CONFIDENTIAL PATIENT QUESTIONNAIRE

This provides the dentist with important information for your Dental Treatment and Oral Health Care.

Name_____ _____ _____
Surname First Names Dr, Mr, Mrs, Miss, Ms, Master

Date of Birth:_____ **NZ Resident: Yes/No Ethnicity**_____

Home Address:_____ **Driver licence/exp NHI#**_____ **ID #**_____

Suburb_____**Zipcode**_____
Home Phone_____ **Work Phone**_____
Mobile Phone_____ **Occupation**_____

Email Address _____

Emergency Contact/Alternate Phone_____**please specify**

Name of School if below 18 years _____

Medical History

Medical Doctors Name/Phone_____

1. **Are you receiving any medical treatment at the present time or been in hospital in the last 2 years**_____**Yes/No**
   Details_____
2. **Are you taking any medicine tablets, capsules or drugs currently? (eg, blood thinners like Aspirin/Warfarin)**___**Yes/No**
   Details_____
3. **Have you experienced any allergies or unusual effects from any tablets, drugs, infections or anaesthetics?** _____**Yes/No**
   Details_____
4. **Have you ever had any of the following? If so, please tick as appropriate**

	Rheumatic Fever		Epilepsy
	Heart Trouble		Anaemia
	High Blood Pressure		Diabetes
	Asthma		Kidney trouble
	Arthritis		Gastric Problems
	Hepatitis- specify A,B, C		Cold sores
	Bronchitis or Chest Problems		Depressive Illness
	Severe Headaches		Drug Dependence

Have you had any prosthetic surgery (eg. Heart valve or Hip Replacement)_____**Yes/No**
Details_____

5. **Woman, Are you Pregnant? If so, how many months:**_____

Dental History

1. **Name of last Dentist and approximate date of last visit**_____
2. **Have you experience excessive bleeding or bruising from dental treatment, cuts or scratches? Yes/No**
3. **Do you become anxious or uncomfortable when you are having dental treatment?**_____**Yes/No**

Referred by: **Website** _____**Google**_____**Social Media**_____ **Another patient/Friend** _____
Street sign_____**Other (Please specify)**_____

PAYMENT IS REQUIRED AFTER EACH CONSULTATION OR TREATMENT.

EFTPOS, CASH, CHEQUE, CREDIT CARDS ARE ACCEPTED Which will you be paying with_____

I give consent for contacting me via email/text message and give consent for photography for record purpose.

Signed: Patient/Parent/Guardian_____**Date:**_____

Please print name if signed by anyone other than patient_____