Submit Form

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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** | ☐ | **Have you recently returned from overseas** |
| ☐ | **Heart Trouble** | ☐ | **Anaemia** | ☐ | **Contact with confirmed/suspected Covid-19** |
| ☐ | **High Blood Pressure** | ☐ | **Diabetes** | ☐ | **Sore Throat** |
| ☐ | **Asthma** | ☐ | **Kidney trouble** | ☐ | **Sneezing or Runny Nose** |
| ☐ | **Arthritis** | ☐ | **Gastric Problems** | ☐ | **Temporary Loss of Smell** |
| ☐ | **Hepatitis- specify A,B, C** | ☐ | **Cold sores** | ☐ | **Fever** |
| ☐ | **Bronchitis or Chest Problems** | ☐ | **Depressive Illness** | ☐ | **Coughing** |
| ☐ | **Severe Headaches** | ☐ | **Drug Dependence** | ☐ | **Difficulty Breathing (Require Immediate Medical Attention)** |

**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**_____
****(BAD DEBTS WILL BE HANDED OVER FOR COLLECTION)**

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

**I confirm all information to be accurate**

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

**Please print name if signed by anyone other than patient**_____