Patient Questionnaire (Confidential)

NEW ZEALAND
DENTAL ASSOCIATION

This questionnaire provides the information your dentist needs for your dental treatment and oral health care.

Preferred Title: MR / MRS / MISS / MS DR / PROF	(surname)	(first names)	
Address			
Email Address(es)			
Telephone	(home)	(work)	(mobile)
Date of birth		Occupation	
When did you last visit a dentist?		Name of your last dentist	
How did you hear of this practice?			
If you are under 16, please give name and address of parent/guardian			
Do you have dental insurance cover?	☐ Yes ☐ No		
Name of your doctor/GP			
Do you smoke?	☐ Yes ☐ No		
Do you prefer:	☐ Amalgam (silver) fillings ☐ Composite (white, non-metal) fillings, if suitable ☐ No preference, guided by dentist ☐ I wish to discuss this with the dentist		

Although rare, accidental injury to staff can occur during handling of used instruments. If this happens during the course of your treatment, our practice requires both patient and staff member to undertake a blood test. Do you agree to a confidential blood test?

☐ Yes ☐ No ☐ I wish to discuss this with the dentist

Please complete the health questionnaire on the other side of this page.

In order to provide the best and safest dental treatment, your dentist needs to know of any medical problems which may affect your treatment.

Have you ever had any of the following (please tick Yes or No):	Cardiovascular:	Heart Murmur	☐ Yes	☐ No
		Rheumatic Fever	☐ Yes	☐ No
		Open heart surgery	☐ Yes	☐ No
		High blood pressure	☐ Yes	☐ No
		Stroke	☐ Yes	☐ No
	Respiratory:	Asthma	☐ Yes	☐ No
		Chest & lung disease	☐ Yes	☐ No
		Sinus/hay fever	☐ Yes	☐ No
	Other:	Epilepsy	☐ Yes	☐ No
		Diabetes	☐ Yes	☐ No
		Kidney problems	☐ Yes	☐ No
		Gastric problems	☐ Yes	☐ No
		Depressive illness	☐ Yes	☐ No
		Radiotherapy	☐ Yes	☐ No
Are you taking any tablets, medicines, pills or drugs? If yes, please list.				
Have you ever had any allergies to medicines, or other substances (such as Latex)? If so, please list.				
Do you have an artificial or prosthetic joint?			☐ Yes	☐ No
Have you ever experienced excessive bleeding or bruising from dental treatment, or at any other time?			☐ Yes	☐ No
Have you ever had contact with:		HIV virus	☐ Yes	☐ No
		Hepatitis B virus	☐ Yes	☐ No
		Hepatitis C virus	☐ Yes	☐ No
Have you ever had an unfavourable reaction to an anaesthetic?			☐ Yes	☐ No
Women: Are you pregnant now? If so, how many weeks?				
Are there any other health matters you need to talk to the dentist about?			☐ Yes	☐ No

I confirm that the information written above is true and correct to the best of my knowledge.

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

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