

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Open heart surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Respiratory:	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Chest & lung disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Sinus/hay fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Other:	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Kidney problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Gastric problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Depressive illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Radiotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis B virus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis C virus	<input type="checkbox"/> Yes	<input type="checkbox"/> 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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