Thorndon Dental Surgery

246 Tinakori Rd
Thorndon, Wellington
NEW ZEALAND
Phone: 04 472 8353
Email: info@thorndondental.co.nz

CONFIDENTIAL PATIENT QUESTIONNAIRE

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

Name: _____
Surname First Names Dr / Mr / Mrs / Miss / Ms

Date of Birth: _____ Occupation: _____

Home Address: _____ (For Students) _____

Suburb _____ College Name _____

City _____ College Year: _____

Post Code _____ Work Phone: _____

Home Phone: _____ Alternate Phone: _____

E-mail Address: _____

Details of person to contact in an emergency: ☐ Please tick if your emergency contact is a patient at our practice

Name: _____ Phone Number: _____

GP/Medical Practice: _____ Phone (If known): _____

MEDICAL HISTORY

1. Are you receiving any medical treatment at the present time? Yes / No

Details: _____

2. Have you been a patient in hospital during the past two years? Yes / No

Reason: _____

3. Have you taken any medicine tablets, capsules or drugs during the past two years? Yes / No

Details: _____

4. Have you experienced any allergies or unusual effects from any tablets, drugs, injections or anaesthetic? Yes / No

Details: _____

5. Are you, or have you been, under the care of a doctor during the past two years? Yes / No

Reason: _____

6. Have you ever had any of the following? If so, please tick as appropriate.

o Rheumatic Fever	o Asthma	o Anaphylaxis	o Kidney Trouble
o Heart Trouble	o Cold Sores	o Anaemia	o Depressive Illness
o High Blood Pressure	o Arthritis	o Diabetes	o Drug Dependence
o Gastric Problems	o Severe Headaches	o Epilepsy	o Tuberculosis
o Bronchitis or Chest Problems	o Seizure	o Stroke	o HIV Positive
o Excessive bleeding/bruising	o Bone disease	o Hepatitis – circle type:	A B C

7. Have you had any prosthetic surgery? (e.g. Heart Valve or Hip Replacement) Yes / No

Details: _____

8. Are you pregnant? If so, how many months: _____ Yes / No

DENTAL HISTORY

1. Name of Last Dental Practice: _____

2. Approximate date of last dental visit: _____ Reason: _____

3. Do you have Dental pain or a Dental problem at present? Yes / No

Details: _____

4. Do you become anxious or uncomfortable when you are having dental treatment? Yes / No

Referred By:

o Google o Street Sign o Another patient/friend: _____ o Other, please specify: _____

Please Note That Payment is Required At Time of Treatment.

☐ **I understand that I will be liable for collection fees of recoverable costs.**

Signed: Patient/Parent/Guardian _____ Date: _____