Greytown Dental
The Hub
78 Main Street
Greytown 5712
Tel: 06 304 8906
Email: contact@greytowndental.co.nz
www.greytowndental.co.nz

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

First Name		Surname	
Title	Mr / Mrs / Ms / Miss / Dr / Prof		
Address			
Email Address		Permission to send emails	☐ YES / ☐ NO
Telephone	Home	Work	Mobile
Date of Birth	/ /	Permission to send texts	☐ YES / ☐ NO
Occupation		Name of School (If under 18yrs)	
Next of Kin Full Name		Next of Kin Phone No.	

Name of your Previous Dentist		When did you last visit a Dentist?	
How did you hear about Greytown Dental?			
Do you have Dental Insurance Cover?		YES / NO	
Name of your Doctor / GP		Doctor / GP's Phone	
Name of GP Practice		NHI Number (If under 18yrs)	

For under 18yrs (please provide contact details for your Parent or Legal Guardian)

Name		Phone	
Address			

Although rare, accidental injury to staff can occur during handling of instruments used. 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

Signature_____

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

MEDICAL HISTORY FORM

Greytown Dental
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Name	

Do you have or have you had any of the following conditions? (tick all that apply)

Heart	☐	Rheumatic Fever	☐	High/Low Blood Pressure	☐	Heart Surgery
	☐	Pacemaker Fitted	☐	Heart Murmur	☐	Angina
	☐	Thrombosis	☐		☐	
	☐	Other Heart Conditions:				
Chest	☐	Bronchitis	☐	Emphysema	☐	Pneumonia
	☐	Chest Surgery	☐	Smoker	☐	Cystic Fibrosis
	☐	Pleurisy	☐		☐	
	☐	Other Chest Conditions:				
Blood	☐	Bleeding	☐	Hepatitis A, B, C or D	☐	H.I.V. / AIDS
	☐	Anaemia	☐	Abnormal Blood Test	☐	Sickle Cell
	☐	Haemophilia	☐	Blood refused	☐	
	☐	Other Blood Conditions:				
Other	☐	Serious Childhood Illness	☐	Diabetes	☐	Liver Disease
	☐	Kidney Disease	☐	Epilepsy	☐	Cancer
	☐	L.A. Experience	☐	Hiatus Hernia	☐	Stroke
	☐	Other Conditions:				
Allergies	☐	Penicillin	☐	Hay Fever	☐	Anti-Tetanus Serum
	☐	Eczema	☐	Aspirin	☐	Asthmatic
	☐	Latex Allergy	☐	Plants	☐	Medicines
	☐	Other Allergy Conditions:				

Warnings	☐	Chest Surgery?	☐	Antibiotic cover required?
	☐	Emphysema / Pneumonia?	☐	Are you pregnant?
	☐	Currently under treatment?	☐	Artificial or prosthetic joint?
	☐	What special precautions should we take?		

Medication	List any medications you are taking:

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