

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	<input type="checkbox"/> YES / <input type="checkbox"/> NO
Telephone	Home	Work	Mobile
Date of Birth	/ /	Permission to send texts	<input type="checkbox"/> YES / <input type="checkbox"/> 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)

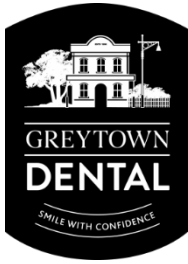
Name		Phone	
Address			

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
 The Hub
 78 Main Street
 Greytown 5712
 06 304 8906

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

Heart	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	Heart Surgery
	<input type="checkbox"/>	Pacemaker Fitted	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Angina
	<input type="checkbox"/>	Thrombosis	<input type="checkbox"/>		<input type="checkbox"/>	
	<input type="checkbox"/>	Other Heart Conditions:				

Chest	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Pneumonia
	<input type="checkbox"/>	Chest Surgery	<input type="checkbox"/>	Smoker	<input type="checkbox"/>	Cystic Fibrosis
	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>		<input type="checkbox"/>	
	<input type="checkbox"/>	Other Chest Conditions:				

Blood	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	Hepatitis A, B, C or D	<input type="checkbox"/>	H.I.V. / AIDS
	<input type="checkbox"/>	Anaemia	<input type="checkbox"/>	Abnormal Blood Test	<input type="checkbox"/>	Sickle Cell
	<input type="checkbox"/>	Haemophilia	<input type="checkbox"/>	Blood refused	<input type="checkbox"/>	
	<input type="checkbox"/>	Other Blood Conditions:				

Other	<input type="checkbox"/>	Serious Childhood Illness	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Liver Disease
	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Cancer
	<input type="checkbox"/>	L.A. Experience	<input type="checkbox"/>	Hiatus Hernia	<input type="checkbox"/>	Stroke
	<input type="checkbox"/>	Other Conditions:				

Allergies	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Anti-Tetanus Serum
	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	Asthmatic
	<input type="checkbox"/>	Latex Allergy	<input type="checkbox"/>	Plants	<input type="checkbox"/>	Medicines
	<input type="checkbox"/>	Other Allergy Conditions:				

Warnings	<input type="checkbox"/>	Chest Surgery?	<input type="checkbox"/>	Antibiotic cover required?
	<input type="checkbox"/>	Emphysema / Pneumonia?	<input type="checkbox"/>	Are you pregnant?
	<input type="checkbox"/>	Currently under treatment?	<input type="checkbox"/>	Artificial or prosthetic joint?
	<input type="checkbox"/>	What special precautions should we take?		

Medication	List any medications you are taking:
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Signed by: Patient / Parent / Guardian

Date: