KATIKATI gentledental

***CONFIDENTIAL* PATIENT QUESTIONNAIRE**

This provides the dentist with important information required for your dental treatment and oral health care.

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

Date of Birth: _____ **Occupation:** _____

Home Address: _____

_____ **Postcode:** _____

Preferred Phone Contact No: _____ ***If mobile: Text? Yes / No***

Email address: _____

Contact person in an emergency:

Name: _____ **Phone Number:** _____

Relationship to contact person (friend or relative): _____

Medical Doctors Name: _____ **Phone (If known):** _____

MEDICAL HISTORY

1. ***Are you taking any medicines, tablets, or drugs at the present time:*** **Yes / No**
   Details: _____
   _____
   _____
   _____
2. ***DO YOU HAVE any allergies to medications, substances, or food?***
   Details: _____
3. Have you ever had any of the following? If so, please tick as appropriate.

☐ Angina/Stroke	☐ Diabetes	☐ Depression
☐ Pacemaker	☐ Cancer	☐ Kidney/Liver Issue
☐ Blood Pressure Issue	☐ Epilepsy/Faints	☐ Bronchitis/Asthma
☐ Arthritis	☐ Infectious Disease	☐ Drug Dependency

☐ *Other please specify:* _____

4. ***Have you had any prosthetic Heart Valve surgery?*** _____ ***Yes/ No***
5. ***Have you ever taken any bone strengthening medications (injection or tablet form)?*** **Yes/ No**
6. **Females only, are you pregnant? How many months:** _____ **Yes/ No**
7. **Do you smoke/ vape? If Yes, how many per day:** _____ **Yes/ No**
8. **Do you drink alcohol? If yes, how many units per week:** _____ **Yes/ No**

DENTAL HISTORY

1. **Name of Last Dentist:** _____
2. **Approximate date of last dental visit:** _____
3. **Do you have Dental pain or a Dental problem at present?** **Yes / No**
   Details: _____
4. **Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches?** **Yes / No**
5. **Do you become anxious or uncomfortable when you are having dental treatment?** **Yes / No**

REFERRED BY: (tick as appropriate)

☐ ***Family/ friend/ dentist:*** _____ ☐ ***Radio advert***

☐ ***Kati Advertiser/Waihi Leader*** ☐ ***Google/ Other search engine/ Website*** ☐ ***Phone book/Yellow pages/Lions book***

☐ ***Other please specify:*** _____

PAYMENT FOR DENTAL TREATMENT: All fees are due for payment on the day of your treatment. I guarantee and agree to pay all invoices rendered by Katikati Gentle Dental. If I fail to do so, I agree to pay penalty interest at 3% per month and all collection costs incurred by Katikati Gentle Dental in recovering any overdue monies owing by me.

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