New Patient Form

114 Lake Road, Northcote, Auckland. Tel: 09 480 6629 dentalstudio114@vodafone.co.nz
http://114dental.co.nz

Please be as accurate as possible when completing this questionnaire. The information you provide is kept strictly confidential.

Title_____ First names_____ Surname_____

Date of birth _____/_____/_____ Occupation_____

Postal Address_____ Postcode_____

Telephone: Mobile_____ Work _____ Home_____

Email _____ I wish to receive emails regarding news or promotions ☐

Name and contact of next of kin _____

Were you referred to the practice by one of our patients? (Please name) _____

How did you hear about us?_____

Name of Last Dentist_____ Date of last visit_____

Name of Medical Practitioner_____Location_____

Are you in any pain presently? Y/N ☐ Do you need to take antibiotics prior to dental treatment? Y/N ☐

Please list the medications you are currently taking._____

Is there anything about your teeth you would like to discuss with the dentist?_____

Do you have any allergies to medicines, anaesthetics, latex, penicillin? Please list _____

Are you a smoker? Y/N ☐ Are you pregnant? Y/N ☐ If so, how many months?_____

Please tick if you have had any of the following:

☐ Anaemia	☐ Depressive Illness	☐ Heart Murmur	☐ Nervous problems	☐ Rheumatic Fever
☐ Arthritis	☐ Diabetes	☐ Hepatitis A,B,C	☐ Osteoporosis	☐ Severe headaches
☐ Asthma	☐ Epilepsy/Seizure	☐ Pacemaker	☐ Stroke	☐ High Blood Pressure
☐ Cancer	☐ Excessive Bleeding	☐ Tuberculosis	☐ Prosthetic Joint	☐ Low Blood Pressure
☐ HIV/Aids	☐ Chest Problems	☐ Gastric issues	☐ Radiotherapy	☐ Hearing/Sight issues
☐ Herpes	☐ Heart conditions	☐ Liver/Kidney problems	☐ Reaction to Anaesthetic	

CONSENT FOR TREATMENT: I authorise the dentist/designated staff to perform all recommended treatment deemed appropriate by the dentist to make a thorough diagnosis. I agree to be responsible for payment of all services rendered. I understand payment is due at time of service. Cost incurred in relation to collection of overdue accounts will be charged to the account holder. By signing below I understand and accept these terms and conditions.

Signed by Patient/Parent/Guardian_____Date ____/_____/_____

PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, EFTPOS, AND MAJOR CREDIT CARDS.