DENTAL ARTISTRY

38 Broadway
Newmarket 1023
Auckland, NZ
Phone: 0800 999 009

CONFIDENTIAL PATIENT QUESTIONNAIRE

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

Last Name: _____First Names: _____ Dr / Mr / Mrs / Miss / Ms

Date of Birth: ____/____/____

Home Address: _____

Mobile: _____ Work Phone: _____ Home Phone: _____

Occupation: _____Email:_____

Work Address: _____

Medical Doctors Name: _____Suburb: _____

Referring Dentists Name: *(if applicable)* _____ Suburb: _____

☐ I give my permission for this email to be used for special offers from Dental Artistry and Implant Solutions.

Details of person to contact in an emergency:

Name: _____ Phone Number/s: _____

Medical History:

1. Are you receiving any medical treatment at the present time? Yes / No
   Details: _____
2. Are you routinely taking any medicine tablets, dietary supplements, capsules or drugs? Yes / No
   Details: _____
3. Have you experienced any unusual effects/allergies from any tablets, injections or anaesthetic? Yes / No
   Details: _____
4. Have you ever had any of the following? If so, please tick as appropriate:

☐ Rheumatic Fever	☐ Heart Murmur	☐ Cancer or Chemotherapy
☐ Heart Trouble or Surgery	☐ Asthma	☐ Arthritis
☐ High Blood Pressure	☐ Diabetes	☐ Auto Immune Illness
☐ Bleeding disorder	☐ Kidney trouble	☐ Latex Allergy
☐ Angina	☐ Gastric problems	☐ Serious Childhood Illness
☐ Pacemaker Fitted	☐ Epilepsy	☐ Severe headaches
☐ Hepatitis – Specify type A, B, C	☐ Hayfever	☐ Drug dependency

5. Have you had any prosthetic surgery? (I.e. Heart Valve or Hip/Knee Replacement) Yes / No
   Details: _____ **If yes, refer to question 6**
6. Has your surgeon advised you that you require Antibiotic Cover for dental treatment? Yes / No
7. Women, are you pregnant? If so, how many months: _____ Yes / No
8. Women, are you breastfeeding? Yes / No
9. Do you smoke? If yes, how many per day? _____ Yes / No

PLEASE CONTINUE OVER THE PAGE

Dental History:

1. Approximate date of last dental visit: _____

2. Have you ever experienced any excessive bleeding or bruising from dental treatment or any cuts or scratches? ○ Yes / No ○

3. What is the purpose of today's visit? _____

Please tick as appropriate the issue you are having:

- ☐ Toothache
- ☐ Missing Teeth
- ☐ Lost filling or cavity
- ☐ Broken or worn teeth
- ☐ Unsatisfactory denture
- ☐ Difficulty or discomfort when chewing
- ☐ Sore or bleeding gums
- ☐ Pain in face or jaw joints
- ☐ Crooked or poorly aligned teeth
- ☐ Mouth ulcers
- ☐ Food trapping
- ☐ Sensitive teeth to either extreme temperature or sweets
- ☐ Rapidly decaying teeth
- ☐ Loosening teeth
- ☐ Discoloured teeth or restorations
- ☐ Unpleasant breath, odour or taste
- ☐ Sounds or clicking from the jaw
- ☐ Grinding or clenching of teeth
- ☐ Bad appearance
- ☐ Dry mouth
- ☐ Cold sores

4. Would you like to have whiter teeth? ○ Yes / No ○

5. If you could change anything about the appearance of your teeth, what would you like to change? ○ Yes / No ○
   Please provide details: _____

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

7. Have you had previous Orthodontic treatment? *(I.e. braces*) ○ Yes / No ○

8. Have you had previous Oral Surgery? ○ Yes / No ○

9. Have you had previous Periodontal Treatment? (*I.e. specialised gum treatment*) ○ Yes / No ○

Referred By:

- ☐ Website
- ☐ Google Review
- ☐ Other, please specify: _____
- ☐ Google Ad
- ☐ Another patient/friend? Name:_____

Our Practice Policies:

We ask that all patients make full payment on the day of their appointment. We will provide you with a written estimate for your dental treatment after your initial appointment. A fee may be charged for missed appointments, appointments cancelled with less than **2 business days' notice** or late arrival to appointments. Unpaid accounts may attract interest and debt collection fees.

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

Thank you for your time.

Send Form

If the above Send Form button does not work, download completed form and send to reception@dentalartistry.co.nz