THE DENTAL CENTRE
PORIRUA

PERSONAL DETAILS:

First Names _____ Surname _____

Date of Birth _____ Title: Dr Mr Mrs Miss Ms Other

Address _____

Phone (H)_____(W) _____ Mobile _____

Email _____ Occupation / School _____

Emergency Contact: Name _____ Relationship to you _____

Phone _____ Dental / Medical Insurance_____

MEDICAL QUESTIONNAIRE: Please tick if yes

- ☐ Heart Problems / Surgery
- ☐ Blood Pressure
- ☐ Rheumatic Fever
- ☐ Blood / Bleeding Disorders
- ☐ Osteoporosis / Bone Problems
- ☐ Have you ever taken Fosamax or another bone medication
- ☐ Radio / Chemotherapy
- ☐ Hepatitis / Liver Disease
- ☐ HIV
- ☐ Smoker
- ☐ Asthma / Lung Problems
- ☐ Diabetes
- ☐ Joint Replacement (when?)
- ☐ Stroke
- ☐ Epilepsy
- ☐ Organ Transplant
- ☐ Pregnant (how many weeks?) _____

Anything else we should know?

Allergies _____

Current Medications _____

GP and Practice _____

Although rare, accidental injury to your dentist and staff can occur from the handling of sharp instruments. If this happens during the course of your treatment, our practice requires both the patient and staff member to undertake a blood test.

Do you agree to a confidential blood test if required? ☐ Yes

I understand that payment is required at the time of treatment / consultation. Missed appointments, late attendance or cancellation with less than 4 hours notice will incur a fee of $85 per 30 minutes of scheduled time.

As a health service provider, The Dental Centreis obligated to treat you in a manner compliant with the Health & Disability Commissioner's Code of Rights. These can be made available to you upon request.

Signature (parent if patient under 16) _____ Date _____