ONE
DENTAL
COSMETIC AND GENERAL DENTISTS

Patient Information Form

Title. Mr / Mst / Mrs / Ms/ Miss/ Dr/ Other_____

Name_____ **DOB**_____

Address_____**Post Code**_____

Home Ph_____**Mobile Ph**_____**Email**_____

Employer_____**Occupation**_____

How did you hear about us?_____

Medical Dr Name and Practice_____

List any medications you are taking_____

_____

Are you allergic to anything?_____

Please tick any of the following conditions you may have:

- ☐ **Asthma**
- ☐ **Chest or lung disease**
- ☐ **Heart Murmur**
- ☐ **Rheumatic fever**
- ☐ **Other heart problems**
- ☐ **High Blood Pressure**
- ☐ **Stroke**
- ☐ **Epilepsy**
- ☐ **Diabetes**
- ☐ **Kidney problems**
- ☐ **Liver problems**
- ☐ **Hepatitis**
- ☐ **Gastric problems**
- ☐ **Bleeding problems**
- ☐ **Depressive illness**
- ☐ **Radiotherapy**
- ☐ **AIDS/HIV**
- ☐ **Joint replacement**

Date placed_____

Any other conditions not listed_____

Do you smoke?_____**Any drug or alcohol addictions?**_____

Women- are you pregnant? Y / N If yes what trimester?_____

Name and contact number of emergency contact_____

Occasionally photos may be taken of your teeth (not your face) – are you happy for these photos to be used on the website? Y / N

By signing this form, you are accepting full financial responsibility for dental treatment (except when covered by the DHB) and that payment is due at the time services are provided. Unpaid accounts will incur additional charges.

Health and safety – Our dental chairs are rated hold to 120kg, we accept no responsibility should injury occur if you are over this rated weight.

Signed_____**Date**_____