TITIRANGI Smiles

In order to get to know you and treat you safely, we would appreciate it if you could complete this confidential new patient questionnaire.

If you require any assistance to complete this form please let us know.

Please print clearly, thank you.

GENERAL

Preferred Pronoun: .... First Name: .... Surname: ....

Contact Number: .... Date of Birth: ....

Email: ....

Address: .... Suburb/City: ....

Occupation: .... School (if applicable) ....

Parent/Guardian name if under 16 ....

Regular Doctor: .... Address: ....

Regular Dentist: .... Address: ....

MEDICAL HISTORY Please tick Yes or No

Condition	Yes	No
Angina	Yes ◯	No ◯
Heart Murmur	Yes ◯	No ◯
Rheumatic fever	Yes ◯	No ◯
Heart Surgery	Yes ◯	No ◯
High Blood Pressure	Yes ◯	No ◯
Stroke	Yes ◯	No ◯
HIV, Hep B or C	Yes ◯	No ◯
Asthma	Yes ◯	No ◯
Chest/Lung Disease	Yes ◯	No ◯
Sinus/Hayfever	Yes ◯	No ◯
Epilepsy	Yes ◯	No ◯
Diabetes	Yes ◯	No ◯
Kidney Problems	Yes ◯	No ◯
Gastric Problems	Yes ◯	No ◯
Depressive Illness	Yes ◯	No ◯
Radiotherapy	Yes ◯	No ◯
Chemotherapy	Yes ◯	No ◯
Arthritis	Yes ◯	No ◯
Joint Replacement	Yes ◯	No ◯
Excessive Bleeding	Yes ◯	No ◯

Other: ....

Have you ever had a serious accident, involving a head injury? ....

Do you have any allergies? ....

Have you ever had a reaction to local anaesthetic? .... Are you Pregnant? ....

Do you take bisphosphonates? ....

Do you smoke/vape? .... How many a day? ....

Do you drink alcohol? .... How many units per week? ....

Do you take any prescribed medications? Please list:

....

....

Do you take any supplements? Please list:

....

TITIRANGI Smiles

Please print clear, thank you.

DENTAL

Reason for attending Titirangi Smiles today?

....

Are you happy with the appearance of your teeth?

....

Would you like whiter teeth?

....

Do you experience:

Bleeding Gums	Yes ◯	No ◯	Staining	Yes ◯	No ◯
Food trapping	Yes ◯	No ◯	Teeth moving	Yes ◯	No ◯
Grinding/Clenching	Yes ◯	No ◯	Gum recession	Yes ◯	No ◯
Clicking/Jaw discomfort	Yes ◯	No ◯	Sensitivity	Yes ◯	No ◯
Broken Teeth	Yes ◯	No ◯	Bad breath	Yes ◯	No ◯

When was your last visit to the dentist?

....

How did you find out about Titirangi Smiles?

....

Do you want to keep your teeth for life?

....

General Practice Information/Terms & Conditions do apply, please ask us for details. Please let us know if you have any medical changes.

Our policy is to receive payment at the end of each visit. As all accounts are to be settled prior to leaving the surgery, any non-payment of treatments will incur additional fees and any cost related to debt collection.

By signing this two page New Patient Form you accept Titirangi Smiles terms and conditions and agree that you have provided correct information to us.

Signature .... Name .... Date ...... / ...... / ......

@titirangismiles
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