denturetech
EXTRAORDINARY DENTURES

PATIENT QUESTIONNAIRE

This questionnaire provides the information our dental team requires to give you the best possible care.

First Name: _____ **Surname:** _____

Title: MR / MRS / MS / MISS / DR OTHER _____ **Date of birth:** ____/____/____

If under 20, name and address of parent /guardian: _____

Address: _____

Suburb: _____ Postcode: _____

Phone Numbers:

Home: _____ Business: _____ Mobile: _____

Email: _____

How do you prefer to be contacted?

- ☐ Home number
- ☐ Business number
- ☐ Mobile number
- ☐ Text message
- ☐ Email
- ☐ Are you happy for us to leave a voice message at any of the above? YES / NO

Medical Doctor/GP: Name: _____

Address: _____

General Dentist: Name: _____

Practice Name: _____

Where did you find us?

- ☐ Website
- ☐ Radio - Station: _____
- ☐ Local paper: _____
- ☐ New Zealand Herald
- ☐ Yellow Pages
- ☐ Local Directory - Book: _____
- ☐ Dentist: _____
- ☐ Friend: _____

PLEASE TURN OVER

CONFDENTIAL HEALTH QUESTIONNAIRE

In order to provide the most comprehensive service, we need to be aware of any medical conditions or medication that may affect your treatment.

PLEASE TICK IF APPLIES.

Have you ever had, or been treated for any of the conditions listed below?

- ☐ Acne (Diagnosed)
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis / Chest problems
- ☐ Cancer (please specify) _____
- ☐ Cold sores
- ☐ Diabetes – Type 1 / Type 2
- ☐ Epilepsy
- ☐ Heart trouble
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Mental Illness (please specify) _____
- ☐ Parkinson's Disease
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Tuberculosis

Do you smoke? YES / NO

Do you believe yourself to be at risk from the HIV and/or Hepatitis virus? YES / NO

If YES, please specify: _____

Allergies:

Latex: YES / NO

Medicines: YES / NO if YES, please specify: _____

Medications: Do you take any of the following?

- ☐ Accutane
- ☐ Anti-histamines
- ☐ Anti-seizure medication
- ☐ Arthritis medications
- ☐ Aspirin
- ☐ Blood pressure medication
- ☐ Chemotherapy agents
- ☐ Ibuprofen
- ☐ Inhalers
- ☐ smoking cessation Nicotine patches
- ☐ Steroids within the last 12 months
- ☐ Vitamins / herbal supplements
- ☐ Warfarin

Please list any other medication you are currently taking:

Are there any other aspects concerning your health that you think we should be aware of?

Signed: _____ **Date:** _____/_____/20_____

~ Thank you for taking the time to complete this questionnaire ~

TELL US ABOUT YOU

At DentureTech we want you to make sure you have the most pleasant experience possible. Sometimes, it is easier to say how you feel by writing it down. Below are a few questions for you to consider, tick any that apply to you and please bring this form along with you to your appointment with us.

Today I would like to talk about the following:

- ☐ New dentures
- ☐ Immediate dentures (your first denture)
- ☐ Partial acrylic dentures
- ☐ Partial metal dentures
- ☐ Partial flexible dentures (Valplast)
- ☐ Implant retained dentures
- ☐ Reline (refitting) of existing denture
- ☐ Repair of existing denture
- ☐ Other: _____

Treat me with care

Tick any of the following if they apply to you so we know how you feel about your appointment today.

- ☐ My time is precious – please don't keep me waiting
- ☐ Please explain my financial options at DentureTech
- ☐ I have had a bad denture experience in the past
- ☐ I am feeling a little nervous about this appointment
- ☐ I have a strong gag reflex
- ☐ I find it uncomfortable to have my mouth open for a long period of time

And lastly, please take a few moments to think about your existing dental situation. List your 'wish list' and concerns in order of importance.

Wish list

1. _____
2. _____
3. _____

Concerns

1. _____
2. _____
3. _____