Nigel Parr – Oral & Maxillofacial Surgeon
B.D.S. (Otago), MB. ChB. (Otago), M.D.S. (Otago)
F.R.C.S. (Edin.), F.F.D.R.C.S. (Irel.)
Home: (09) 520-0588
Mobile: 021-555-490
www.nigelparroralsurgeon.co.nz

Green Lane Surgical Day Stay Ltd
11 Green Lane East
Remuera
Auckland 1050
Ph.: (09) 529-5061
Fax: (09) 529-5063

Accredited to:
NZS 8164:2005
Day-Stay Surgery & Procedures

PATIENT MEDICAL HISTORY QUESTIONNAIRE

CONFIDENTIAL

Mr / Mrs / Miss / Ms / Dr *(please circle)*

SURNAME.....

FIRST NAMES..... **DOB**..... /..... /.....

RESIDENTIAL ADDRESS..... **POSTAL CODE**.....

POSTAL ADDRESS *(IF DIFFERENT TO ABOVE)*..... **POSTAL CODE**.....

PHONE NUMBERS – HOME..... **WORK**..... **MOBILE**.....

OCCUPATION..... **EMAIL** .....

NAME & ADDRESS OF NEXT OF KIN.....

RELATIONSHIP *(e.g. partner/husband/wife/parent)*..... **PHONE**.....

Do you have any particular special needs or expectations that you wish to make us aware of?.....

DO YOU HAVE: A disability requiring assistance? Sensory Deficits i.e. deafness/visual impairment?
Any physical limitations? Cultural needs? Is English your first language?

Please note.....

DO YOU HAVE MEDICAL INSURANCE? NAME & POLICY & NUMBER.....
(As this is a specialist practice, your treatment may be covered – If you are unsure, please ask at reception)

If a third party such as Medical Insurance or ACC is involved in the reimbursement for your treatment, we remind you to confirm the situation with them before treatment commences.

NAME OF PERSON WHO REFERRED YOU.....

NAME & ADDRESS OF YOUR DENTIST.....

NAME & ADDRESS OF YOUR DOCTOR.....

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Please circle if yes)

Rheumatic Fever	Asthma	Heart Ailments / Surgery	Fits or Epilepsy
Excessive bleeding	High blood pressure	Diabetes	Hepatitis
	Kidney Disease	Osteoporosis	Artificial joint replacement

Have you had any other serious illness not listed above? Yes / No.....

Have you ever had any previous operations? Yes / No.....

Are you currently receiving medical attention? Yes / No.....

Please list any medications you are currently on (including Homeopathic) .....

Have you ever had an **allergic reaction** to any medication, injections or sticking plasters? Yes / No.....

Do you smoke? Yes / No

Are you likely to be at risk of HIV infection or Hepatitis B? Yes / No

Female patients – Are you pregnant or breast-feeding? Yes / No

I give you permission to exchange information with my dentist, doctor and other medical or dental professionals. I understand that this information will be confidential. I agree to be contacted regarding aspects of my care. I agree that email can be used as a means of contact and exchange of information with myself, my dentist, doctor or other medical or dental professionals.

PATIENT'S SIGNATURE:..... **DATE:**.....
(Parent or guardian is to sign for the patient if he / she is under the age of 16)