UNIVERSITY OF OTAGO
A Place Dunedin College
Te Whare Wānanga o Otāgo

Faculty of Dentistry
Te Kaupeka Pūniho
New Zealand's National Centre for Dentistry

Patient Enrolment Form

First Name(s): _____
First *Middle*

Family Name: _____
Last Name(s)

Previous Name: (if applicable eg: Maiden Name) _____ Preferred Name: _____

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other: _____ Date of Birth: _____
DD/MM/YYYY

Gender: Male ☐ Female ☐ Unstated ☐ Gender Diverse ☐

Address: _____
Number *Street Address*

_____
Suburb *Town/City* *Post Code*

Preferred contact number

Home: _____ ☐

Work: _____ ☐

Mobile: _____ ☐

Send text reminders to this number? Yes ☐ No ☐

Email: _____

Next of Kin Details (or Primary Guardian Contact Details)

Name of Next of Kin: (if applicable) _____
First Name *Last Name*

Relationship to Patient: (if applicable) _____ Date of Birth: _____
DD/MM/YYYY

Address: _____
Number *Street Address*

_____
Suburb *Town/City* *Post Code*

Home: _____ Primary Caregiver?

Work: _____ Yes ☐ No ☐

Mobile: _____

Email: _____

Appointment Preferences

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	☐	☐	☐	☐	☐
PM	☐	☐	☐	☐	☐

Ethnicity

Which ethnic group(s) do you belong to? *(Tick which one/s apply)*

NZ European/ Pakeha ☐ | NZ Māori ☐ | Fijian ☐ | Cook Island Māori ☐ | Indian ☐ | Samoan ☐ | Niuean ☐ | South East Asian ☐ | Chinese ☐ | I'd prefer not to say ☐

Middle Eastern ☐ | African ☐ | European ☐ | Latin American / Hispanic ☐ | Other: (Please specify):

Preferred Language: English ☐ | Cantonese ☐ | Hindi ☐ | Arabic ☐ | NZ Māori ☐ | Samoan ☐

Other (please specify) _____

Do you require an interpreter: Yes ☐ No ☐

Financial Details

Do you receive any forms of financial assistance from Work and Income? Yes ☐ No ☐

If Yes (please tick):

Sole Parent Support ☐ | NZ Superannuation ☐ | StudyLink ☐ | Sickness ☐ | Job Seeker Support ☐ | Supported Living Payment ☐

Other: (Please specify): _____

Occupation: (Please specify): _____

UoO Student ID: (if applicable): _____

Is this visit related to an Accident? Yes ☐ No ☐ Claim No: _____

Community Service Card

Do you have a Community Services Card? (If Yes, please present card at counter)	Yes ☐	No ☐	Details to be completed by Staff Card No:
Do you have a High User Card? (If Yes, please present card at counter)	Yes ☐	No ☐	Issue Date: Expiry Date:
Are you a NZ Citizen or Permanent Resident? (Please tick)	Yes ☐	No ☐	If no, please provide: Visa expiry date: Passport Number:
Overseas Address: (If applicable)			

For Patients under 18

If patient is under 18, and enrolled or attending Secondary OR Tertiary education, OR attending a training program:

Are you enrolled in the Adolescent Oral Health Service?	Yes ☐	No ☐
If Yes, with The School or Dentistry or Private Dentist: (Please provide name):		
Name of School/Institution attending:	School Year: (e.g Year 9)	

If patient is enrolled or attending Pre-School, Primary or Intermediate school education:

Has patient been referred by a School Dental Therapist? (Please tick)	Yes ☐	No ☐
If Yes, please provide School Dental Therapist:		
If No, please give details of who has referred patient:		
Name of School/Pre-school attending:		

If someone else is paying for your treatment, please provide the following details

Full name of person paying for treatment:

Address of person paying for treatment:

Date of Birth of person paying for treatment: DD/MM/YYYY

Contact number of person paying for the Treatment:

Has the responsible party agreed to pay for treatment: (Please tick) Yes ☐ No ☐

Signature: Date:

Disclaimer and Signature

PAYMENT:

- I understand that I may not receive any form of Government Financial assistance. If not, I am obliged to pay the fee for treatment received and any cost incurred in the recovery of this debt.
- Payment must be paid in full on day of treatment unless a payment plan has been agreed in writing prior to receiving treatment
- I understand that if my account has been sent for collection and remains unpaid, any additional invoice will automatically be forwarded for collection.
- I understand that if I default in my payment obligations to you, information about that default may be given to a credit reporting agency and they may give information about my default to other authorized credit providers.

DECLARATION:

I consent to the personal information which I have provided to the University being used for purposes related to the matters in which I am involved in my capacity as a patient and as required by protocols between external agencies and the University. I understand that without this consent my enrolment application cannot proceed. I understand that information relevant to their duties may be used by:

- Staff of the Faculty of Dentistry.
- Student in training at the Faculty of Dentistry.
- Ministries of Education and Health and their agencies (Statistical purpose, funding audits).
- Work and Income and Accident Compensation Corporation (patient financial assistance).
- Other agencies where disclosure is required for data matching or the maintenance of law and order as defined in the Privacy Act 1993.
- I understand that I have the right to see and correct, as necessary, the information that I have provided.
- I understand that the time taken for treatment carried out by a student will be longer than with a regular dentist.

Signature: _____ Date: _____

Name of person fill out form.
if different from above _____

Relationship to patient: _____

Date: _____

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NEW ZEALAND

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PATIENT HEALTH QUESTIONNAIRE

Full Name: _____ Address: _____

Date of Birth: _____ _____

MEDICATIONS

You must list **ALL** the medications you are currently taking before you can receive treatment. If you do not know what you take, please obtain a list from your doctor or pharmacist. Please also include any over the counter medications or natural remedies

_____ _____ _____

_____ _____ _____

Do you consent to us contacting your GP or the hospital to access your medical records? Y/N

YOUR CARE TEAM

Who is your general medical practitioner (doctor)? _____

Who is your specialist (if applicable)? _____

Who is your general dental practitioner (dentist)? _____

MEDICAL CONDITIONS

Do you currently, or have you ever, suffered from any of the following problems or conditions?

CARDIAC (HEART)

Please circle the response that applies:

Angina	Y/N	Irregular heartbeats (arrhythmias)	Y/N	Rheumatic Fever	Y/N
Heart Attack	Y/N	Fluttering heart beat (atrial fibrillation)	Y/N	Heart valve problems	Y/N
High blood pressure (hypertension)	Y/N	Heart Murmur	Y/N	Infective Endocarditis	Y/N
Pacemaker	Y/N			Other	Y/N

Details: _____

RESPIRATORY (BREATHING)

Please tick the box for each condition:

Asthma	Y/N	Chronic Obstructive Pulmonary Disease (COPD)	Y/N	Cystic Fibrosis	Y/N
Smoker	Y/N			Malignant Hyperthermia	Y/N
- Number per day ____		Obstructive Sleep Apnoea (OSA)	Y/N	Other	Y/N

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HAEMATOLOGICAL AND ONCOLOGY (BLOOD OR CANCER)

Please tick the box for each condition:

Inherited Bleeding Disorder	Y/N	Acquired Bleeding Disorder	Y/N	- Other	Y/N
- Haemophilia	Y/N	- Thrombocytopenia	Y/N	Cancer	Y/N
- Von Willebrands	Y/N	- Antiplatelet Drugs	Y/N	Other	Y/N
- Other	Y/N	- Anticoagulant Drugs	Y/N		

Details: _____

INFECTIOUS DISEASES

HIV	Y/N	Hepatitis	Y/N
TB	Y/N	Other	Y/N

Details: _____

OTHER CONDITIONS OR DISABILITIES

Arthritis	Y/N	Intellectual Disorder	Y/N	Epilepsy	Y/N
Joint Replacement	Y/N	Down Syndrome	Y/N	Brain Injury	Y/N
Diabetes	Y/N	Dementia	Y/N	Osteoporosis	Y/N
- Insulin Controlled (Type 1) Y/N		Autism	Y/N	Gastric Reflux	Y/N
- Diet Controlled (Type II) Y/N		Kidney Disease	Y/N	Pregnancy	Y/N
		Liver Disease	Y/N	- Due Date: _____	
Depressive Illness	Y/N	Cerebral Palsy	Y/N	Other	Y/N
Anxiety	Y/N	Physical Disability	Y/N		
Psychiatric Disorder	Y/N	Stroke	Y/N		

Details: _____

ALLERGIES

Please list any drug or medication allergies (and what your reaction was):

_____

Please list any food allergies: _____

Please list any other allergies (eg. latex): _____

OTHER NEEDS

Wheelchair User	Y/N	Vision Impairment	Y/N	Do you feel anxious about receiving dental treatment? Y/N	
Hearing Impairment	Y/N	Interpreter Required	Y/N		

Has your doctor told you that you need antibiotic or corticosteroid cover for dental work? Y/N

I confirm that this form is correct to the extent of my knowledge. I will inform my care provider of any change to the above or to my medications:

Signed: _____ Date: _____

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