

CLINIQUE DENTAIRE DORVAL

PATIENT REGISTRY

This information is confidential

Last name: _____ First name: _____ Sex: M ___ F ___

Address: No _____ Street _____ apt _____ City _____

Postal code _____

- Date of birth: Day _____ Month _____ Year _____
- Child's guardian (in case of a child): _____
- Home phone: _____
- Work phone: _____ Ext: _____
- Can we call you at work? Yes _____ no _____
- Cell phone: _____
- Email address: _____
- Occupation: _____
- Employer: _____
- Medical card's number: _____ Expiration date: _____

Do you have dental insurance? Yes _____ No _____

If you have insurance, please give your insurance's card to the receptionist.

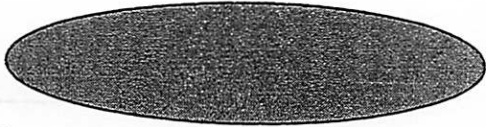
Do you have unemployment insurance? Yes _____ No _____

If you have, please give your unemployment insurance's card to the receptionist.

Referred by: Mr. or Mrs.: _____

Internet _____ Newspaper _____ Flyer _____ Passing by _____ Yellow pages _____

PATIENT NAME: _____



DENTAL FILE

Confidential Questionnaire of Introduction

- | | <u>YES</u> | <u>NO</u> |
|--|------------|-----------|
| 1. Are you presently under a doctor's care? _____ | ___ | ___ |
| 2. Are you presently taking any drug or medication? _____ | ___ | ___ |
| 3. Have you taken any in the last six months? _____ | ___ | ___ |
| 4. Are you pregnant : _____ | ___ | ___ |
| 5. Are you taking any birth control pill? _____ | ___ | ___ |
| <i>Are you suffering or have you ever suffered from :</i> | | |
| 6. Heart disease (stroke, angina, valvular problems, murmur) _____ | ___ | ___ |
| 7. Rheumatic fever : _____ | ___ | ___ |
| 8. Prolonged bleeding : _____ | ___ | ___ |
| 9. Anemia : _____ | ___ | ___ |
| 10. Blood pressure : <i>High</i> ___ <i>Low</i> ___ | ___ | ___ |
| 11. Frequent colds or sinusitis : _____ | ___ | ___ |
| 12. Tuberculosis or lung problems : _____ | ___ | ___ |
| 13. Digestive problems : _____ | ___ | ___ |
| 14. Stomach ulcer : _____ | ___ | ___ |
| 15. Liver disease (hepatitis A, B, C, cirrhosis, etc.) : _____ | ___ | ___ |
| 16. Kidney disease : _____ | ___ | ___ |
| 17. Venereal disease : _____ | ___ | ___ |
| 18. Diabetes : _____ | ___ | ___ |
| 19. Thyroid problems : _____ | ___ | ___ |
| 20. Skin disease : _____ | ___ | ___ |
| 21. Eye problems : _____ | ___ | ___ |
| 22. Arthritis : _____ | ___ | ___ |
| 23. Epilepsy : _____ | ___ | ___ |

- | | <u>YES</u> | <u>NO</u> |
|---|------------|-----------|
| 24. Nervous disorders : _____ | ___ | ___ |
| 25. Frequent headaches : _____ | ___ | ___ |
| 26. Dizziness and/or fainting spells : _____ | ___ | ___ |
| 27. Earaches : _____ | ___ | ___ |
| 28. Hay fever: _____ | ___ | ___ |
| 29. Asthma? _____ | ___ | ___ |
| 30. Do you smoke? _____ | ___ | ___ |
| 31. Have you ever had radiotherapy or/and Chemotherapy treatments? _____ | ___ | ___ |
| 32. Are you an HIV virus carrier? _____ | ___ | ___ |
| 33. Do you have AIDS symptoms? _____ | ___ | ___ |
| 34. Do you have artificial joints (knee, hip, etc.) : _____ | ___ | ___ |
| 35. Do you have any of the following allergies? | | |

- | | <u>YES</u> | <u>NO</u> | <u>YES</u> | <u>NO</u> |
|--------------------|------------|-----------|---------------------------|-----------|
| Food : _____ | ___ | ___ | Sulfonamides : _____ | ___ |
| Penicillin : _____ | ___ | ___ | Codeine : _____ | ___ |
| Aspirin : _____ | ___ | ___ | Local anaesthesia : _____ | ___ |
| Iodine : _____ | ___ | ___ | Others : _____ | ___ |

36. Were you ever hospitalized or have you undergone surgery other than dental?
If so, indicate which ones and when?

DENTAL HISTORY

Are you anxious about your dental visits? _____
Date and reason of your last visit to the dentist? _____
Date of your last full dental exam? _____

- | <u>HAVE YOU PREVIOUSLY HAD DENTAL TREATMENTS SUCH AS:</u> | <u>YES</u> | <u>NO</u> |
|---|------------|-----------|
| 1. Oral hygiene instructions : _____ | ___ | ___ |
| 2. Gum treatments : _____ | ___ | ___ |
| 3. Orthodontic treatments : _____ | ___ | ___ |
| 4. Root canal treatments : _____ | ___ | ___ |
| 5. Dental filings : _____ | ___ | ___ |
| 6. Crowns or/and bridges : _____ | ___ | ___ |

- | | <u>YES</u> | <u>NO</u> |
|---|------------|-----------|
| 7. Partial or/and complete dentures : _____ | ___ | ___ |
| 8. Surgical treatments or extractions : _____ | ___ | ___ |
| 9. Dental implants : _____ | ___ | ___ |
| 10. X-Rays : _____ | ___ | ___ |
| 11. Teeth whitening : _____ | ___ | ___ |
| 12. Others : _____ | ___ | ___ |

I the undersigned, hereby declare that I have read, understood, and answered the above medical-dental questionnaire to the best of my knowledge. I also hereby promise to inform you of any change to my health. I authorize the settling up of my dental file, its follow-up, as well as my registration on the recall list(s) of the treating dentist(s). I have been informed that my file will be kept in the office at all times and that only the dentist(s) and his/her (their) auxiliary personnel will have access to it. I have also been informed of my right to consult my file, to request that it be corrected, if necessary, and to remove my name from the recall list.

I acknowledge that I have read the answers to the above questionnaire and that I have taken the customary measures, as The case may be.

PATIENT'S signature : _____
Date : _____

DENTIST'S signature : _____ Date : _____