CONFIDENTIAL QUESTIONNAIRE OF INTRODUCTION

Name:	
Medicare no.:	
Expiration:	
E-mail: Social Welfare covering: Yes □ No □	
Dental insurance: Yes □ No □	
Name of the insurance company:	
Name of insured:	
Employer:	
Occupation:	
Referred by:	Spoken language: Fr 🗆 Eng. 🗅 Other
In case of emergency person to reach: Name:	
	,
Where did you find our phone number:	
Ī	MEDICAL HISTORY
	Yes No
Are you presently under a doctor's care?	
If yes, why?Phone: (
Are you presently taking any drugs or medication	
or have you taken any in the last six months?	
If yes, which? Date of Delivery	
Are you pregnant? Date of Delivery	
Are you taking any birth control pill? Do you have any allergies or reactions to the follow	
Yes No	Yes No Yes No
food 🗆 🗆 sulfonamide	
penicillin □ □ codeine local anesthesia □ □ anti-inflamı	A
jewellery \square latex	
others? Which?	
Are you suffering or have you ever suffered from .	
Yes No heart disease □ □	tuberculosis or lung problems ☐ ☐
(stroke, angina)	do you have any joints problems \Box
rheumatic fever	do you have any artificial joints
cardiac valvular problems	liver disease (hepatitis A,B,C) \square \square kidney disease (dialysis) \square \square
do you have a pacemaker \square high blood pressure \square \square	kidney disease (dialysis) \square sexually transmitted diseases \square \square
low blood pressure	diabetes \Box
frequent colds or sinusitis	thyroid problems
hay fever	skin problems
asthma	eye problems (glaucoma) \square \square epilepsy \square \square
stomach ulcers	nervous disorders
blood disease	do you smoke? How much ? □
anemia 🔲 🗎	have you ever had treatments:
abnormal bleeding	radiotherapy or/and chemotherapy \square \square Do you have HIV? \square \square
arthritis \square Cholesterol \square	Do you have HIV? \square \square \square Do you have AIDS? \square \square
Were your ever hospitalized or have undergone sur	
If so, indicate which ones and when?	
	$\underline{\hspace{1cm}} (See other side) \rightarrow$

DENTAL HISTORY

Reason for today's visit :							
Why are you consulting a new	dentist?	1 (2)					
When was the last time you vi What treatment did you receiv							
Have you had any negative ex	periences	s with a dentist?					
Have you previously had treat							
	Yes	No			Yes	No	
Dentures			Do you belie	ve in?			
if yes when?root canal treatments			losing your t	eeth one day?			
braces				nture one day?			
			Yes	No			
Does food get lodged between	your tee	eth?					
Do you grind/ clench your teet							
Are your teeth sensitive to hot acid, citrus fruits or pr		igar					
Do your gums bleed?							
Are your jaws sensitive when	you wak	e up?					
Do you use a toothbrush? How							
Do you floss? How many time Do you snore?							
Do you have a recuperative sle							
Are you sleepy during the day	?						
Do you avoid showing your te							
Do you have spaces between y or you would like to improve?		that bother you					
Do you have teeth that are cro		nisaligned	_				
that bother you or would like t		/e?					
Would you like to have whiter		"					
Are you satisfied with your Breath							
appearance of your teeth							
What changes would you make	e to your	smile if you had	a magic wand?			_	
						 	
* a			ointment Po				1.1.
In the event that your appoint thus, another patient could be			firmed 24 hour		ve reserve	the right to	cancel it;
In the event that your appoint thus, another patient could ben		could not be con	firmed 24 hour Initials:	rs in advance, w	ve reserve	the right to	cancel it;
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