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: _____________________________________
Phone: (_____) __________________

Where did you find our phone number: ____

MEDICAL HISTORY

	Yes	No
Are you presently under a doctor's care?	☐	☐
If yes, why ? ____		
Name: __________________________ Phone: (__ ___) ______________		
Are you presently taking any drugs or medication or have you taken any in the last six months?	☐	☐
If yes, which? ____		
Are you pregnant? Date of Delivery _______________________	☐	☐
Are you taking any birth control pill?	☐	☐

Do you have any allergies or reactions to the following:

	Yes	No		Yes	No		Yes	No
food	☐	☐	sulfonamides	☐	☐	iodine	☐	☐
penicillin	☐	☐	codeine	☐	☐	aspirine	☐	☐
local anesthesia	☐	☐	anti-inflammatories	☐	☐			
jewellery	☐	☐	latex	☐	☐			

others? Which? ____

Are you suffering or have you ever suffered from …?

	Yes	No		Yes	No
heart disease (stroke, angina)	☐	☐	tuberculosis or lung problems	☐	☐
			do you have any joints problems	☐	☐
rheumatic fever	☐	☐	do you have any artificial joints	☐	☐
cardiac valvular problems	☐	☐	liver disease (hepatitis A,B,C)	☐	☐
do you have a pacemaker	☐	☐	kidney disease (dialysis)	☐	☐
high blood pressure	☐	☐	sexually transmitted diseases	☐	☐
low blood pressure	☐	☐	diabetes	☐	☐
frequent colds or sinusitis	☐	☐	thyroid problems	☐	☐
hay fever	☐	☐	skin problems	☐	☐
asthma	☐	☐	eye problems (glaucoma)	☐	☐
digestive problems	☐	☐	epilepsy	☐	☐
stomach ulcers	☐	☐	nervous disorders	☐	☐
blood disease	☐	☐	do you smoke? How much ?_____	☐	☐
anemia	☐	☐	have you ever had treatments :		
abnormal bleeding	☐	☐	radiotherapy or/and chemotherapy	☐	☐
arthritis	☐	☐	Do you have HIV?	☐	☐
cholesterol	☐	☐	Do you have AIDS?	☐	☐

Were your ever hospitalized or have undergone surgery other than dental? Yes ☐ No☐
If so, indicate which ones and when? ____
____
____(See other side) →

____
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fortin poirier CLINIQUE DENTAIRE

DENTAL HISTORY

Reason for today's visit : ____

Why are you consulting a new dentist? ____

When was the last time you visited the dentist? ____

What treatment did you receive? ____

Have you had any negative experiences with a dentist? _______________________________________

Have you previously had treatments such as:

	Yes	No
Dentures	☐	☐
if yes when? ____________________		
root canal treatments	☐	☐
braces	☐	☐

Do you believe in …?	Yes	No
losing your teeth one day?	☐	☐
wearing a denture one day?	☐	☐

	Yes	No
Does food get lodged between your teeth?	☐	☐
Do you grind/ clench your teeth? Night ☐ Day ☐	☐	☐
Are your teeth sensitive to hot, cold, sugar acid, citrus fruits or pressure?	☐	☐
Do your gums bleed?	☐	☐
Are your jaws sensitive when you wake up?	☐	☐
Do you use a toothbrush? How many times a day? _______	☐	☐
Do you floss? How many times per week? __________	☐	☐
Do you snore?	☐	☐
Do you have a recuperative sleep?	☐	☐
Are you sleepy during the day?	☐	☐
Do you avoid showing your teeth when you smile?	☐	☐
Do you have spaces between your teeth that bother you or you would like to improve?	☐	☐
Do you have teeth that are crooked or misaligned that bother you or would like to improve?	☐	☐
Would you like to have whiter teeth?	☐	☐

Are you satisfied with your …?	Yes	No
Breath	☐	☐
appearance of your teeth	☐	☐

What changes would you make to your smile if you had a magic wand? _________________________

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Appointment Policy

In the event that your appointment could not be confirmed 24 hours in advance, we reserve the right to cancel it; thus, another patient could benefit. Initials: __________

Payment Policy

I am responsible for the consultation and treatment fees. If no payment has been received within 90 days of the visit, I have been informed that the dental clinic will be using the services of a collection agency and additional fees may apply such as interest at a rate of 1.5%, collection agency fees or other cost.

I, the undersigned, hereby declare that I have read, and 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 setting up of my dental file, its follow-up, as well as my registration on the recall list of the treating dentist. I have been informed that my file will be kept in the office at all times and that only the dentist and his/her 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.

Signature (patient or guardian) : ___________________________ Date : _____________

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.

Signature (attending) : __________________________________ Date : _____________

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