CLINIQUE DENTAIRE DORVAL

PATIENT REGISTRY

<u>This information is confidential</u>

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.

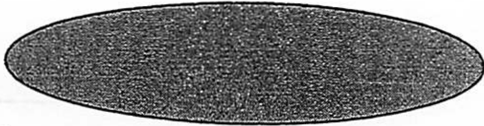
Do you have unemployment insurance? Yes____ No______

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

		YES	NO
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?		
	Are you suffering or have you ever suffered from :		
6.	Heart disease (stroke, angina, valvular problems, murmur)		
7.	Rheumatic fever :		
8.	Prolonged bleeding :		
9.	Anemia :		
10.	Blood pressure : *High* ____ *Low* ____		
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 :		
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?

	YES	NO		YES	NO
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?

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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? ______

HAVE YOU PREVIOUSLY HAD DENTAL TREATMENTS SUCH AS:	YES	NO
1. Oral hygiene instructions :		
2. Gum treatments :		
3. Orthodontic treatments :		
4. Root canal treatments :		
5. Dental fillings :		
6. Crowns or/and bridges :		
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 night 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 :