CONFIDENTIAL REGISTRATION QUESTIONNAIRE

First name_____ Family name_____ Date of birth___/___/___
Sex : male ☐ female ☐ D M Y
Address : No_____ Street_____ Apt_____
City _____ Postal code _____
Tel. to reach you: home_____ Work_____ Cell_____
Email _____
In case of an emergency, contact_____Tél._____

Reason for visit_____

Are you claustrophobic? Yes ☐ No ☐

DENTAL HISTORY

Have you ever had the following dental treatments or dental problems :

Gum disease	☐	Dental extractions	☐
Orthodontic treatment	☐	Dental implants	☐
Root canal treatment	☐	Surgery to the jaws	☐
Bone grafts	☐	Trauma or accident to the face or mouth	☐

Other_____

MEDICAL HISTORY

Are you actually under the care of a medical doctor?
Reason _____
Name of doctor _____

Do you take medication? Yes ☐ No ☐
Do you smoke? Yes ☐ No ☐
Do you snore? Yes ☐ No ☐

Have you ever had or been treated for:

Hypertension	☐	Renal disease	☐
Hypotension	☐	Hepatitis A ou B	☐
Rheumatic fever	☐	Digestive problems	☐
Asthma	☐	Epilepsy	☐
Anemia	☐	Tendancy to faint	☐
Liver disease	☐	Tuberculosis	☐
Diabetes	☐	Thyroid disease	☐
Cancer	☐	Chemotherapy	☐
Radiotherapy	☐	Hospitalization	☐

Allergies_____
_____
Other_____

Women only : are you pregnant? Yes ☐ No ☐

Signature of patient / guardian signature _____ Date_____
Dentist signature _____ Date_____

Dr Manon Paquette, DMD, Cert. oral and maxillofacial radiol., M.S. (Diag. Sc. Licence ODQ 15303)