

**CONFIDENTIAL QUESTIONNAIRE OF INTRODUCTION**

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Apt No.** \_\_\_\_\_ **City:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_  
**Home Phone No:** \_\_\_\_\_ **Work No:** \_\_\_\_\_ **Cell no:** \_\_\_\_\_ **E-Mail:** \_\_\_\_\_

**Sex:** M:  F:  **Birthdate:** Year \_\_\_\_ Month: \_\_\_\_ Day: \_\_\_\_  
**Guardian:** \_\_\_\_\_ **Medicare No:** \_\_\_\_\_ **Seq #** \_\_\_\_ **Exp Dte:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Referred By:** \_\_\_\_\_ **Reason for Visit:** \_\_\_\_\_

**Private Insurance:** Yes  No   
 Ins Company Name: \_\_\_\_\_  
 Group Policy Number: \_\_\_\_\_  
 Certificate # \_\_\_\_\_  
 Name of Insured: \_\_\_\_\_  
 Date of Birth of Insured: Year \_\_\_\_ Month \_\_\_\_ Day \_\_\_\_

**Social Assistance:** Yes  No

**For Office use only:**

**MEDICAL HISTORY**

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| <p><b>1</b> Are you presently under a doctor's care? Yes_ No_</p> <p>Last Name: _____ First Name: _____<br/>                 Telephone #: _____</p> <p><b>2</b> Are you presently taking any drugs/medication, or have you taken any in the last six months? Yes_ No_</p> <p>If so, which: _____</p> <p><b>3</b> Did you recently experience significant weight loss/gain? Yes_ No_</p> <p><b>4</b> Are you pregnant? Yes_ No_</p> <p><b>5</b> Are you taking any birth control pills? Yes_ No_</p> | <p><b>21</b> Eye problems..... Yes_ No_</p> <p><b>22</b> Arthritis ..... Yes_ No_</p> <p><b>23</b> Epilepsy..... Yes_ No_</p> <p><b>24</b> Nervous disorders..... Yes_ No_</p> <p><b>25</b> Frequent headaches..... Yes_ No_</p> <p><b>26</b> Dizzy spells or fainting spells ..... Yes_ No_</p> <p><b>27</b> Earaches..... Yes_ No_</p> <p><b>28</b> Hay fever ..... Yes_ No_</p> <p><b>29</b> Asthma ..... Yes_ No_</p> <p><b>30</b> Do You Smoke? ..... Yes_ No_</p> |
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**Are you suffering or have you ever suffered from?**

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| <p><b>6</b> Heart Disease..... Yes_ No_ (stroke, angina, valvular problems, murmur)</p> <p><b>7</b> Rheumatic fever..... Yes_ No_</p> <p><b>8</b> Prolonged bleeding ..... Yes_ No_</p> <p><b>9</b> Anemia ..... Yes_ No_</p> <p><b>10</b> High ____ Low ____ Blood pressure ..... Yes_ No_</p> <p><b>11</b> Frequent colds or sinusitis..... Yes_ No_</p> <p><b>12</b> Tuberculosis or lung problems ..... Yes_ No_</p> <p><b>13</b> Digestive problems..... Yes_ No_</p> <p><b>14</b> Stomach ulcer ..... Yes_ No_</p> <p><b>15</b> Liver disease (hepatitis A, B, C, cirrhosis, etc)..... Yes_ No_</p> <p><b>16</b> Kidney disease..... Yes_ No_</p> <p><b>17</b> Veneral Disease (V.D.)..... Yes_ No_</p> <p><b>18</b> Diabetes ..... Yes_ No_</p> <p><b>19</b> Thyroid problems..... Yes_ No_</p> <p><b>20</b> Skin disease..... Yes_ No_</p> | <p><b>31</b> Have you ever had radiotherapy and/or chemotherapy treatments (tumor)? Yes_ No_</p> <p><b>32</b> Do you have AIDS symptoms? ..... Yes_ No_</p> <p><b>33</b> Do you have HIV or are you an AIDS virus carrier? Yes_ No_</p> <p><b>34</b> Do you have artificial joints (hip, knee, etc) ?..... Yes_ No_</p> <p><b>35</b> Do you have any of the following allergies? Yes_ No_</p> <p>Penicillin..... Yes_ No_ Iodine ..... Yes_ No_</p> <p>Codeine ..... Yes_ No_ Sulfonamides..... Yes_ No_</p> <p>Local anaesthesia...Yes_ No_ Food ..... Yes_ No_</p> <p>Specify _____ Other anitbiotics.. Yes_ No_</p> <p>Others _____</p> <p><b>36</b> Were you ever hospitalized or have you undergone surgery other than dental? If so, indicate what and when.</p> <p>_____ Date: _____</p> <p>_____ Date: _____</p> <p><b>37</b> Is there anything regarding your health you wish to discuss privately with your dentist? Remarks: _____</p> |
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I, the undersigned, hereby declare that I have read, understood and answered the above medical 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(s) of the attending 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 auxillary 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.

**Cancellation/No Show Policy:** Our cancellation policy states that if you are unable to keep an appointment, please advise us **24** hours in advance, otherwise you will be charged a **fee of \$35.00**. The amount cannot be recorded on insurance receipt.  
**I hereby confirm I have been made aware of the Cancellation/No Show policy of the Centre Dentaire Lasalle and that I am personally responsible for the payment if this policy is not respected.**

Signature	Date:	Signature	Date:
Patient or Guardian:		Attending Dentist:	