DR LUC DUCHARME & ASSOCIATES

WELCOME TO OUR OFFICE

PLEASE PRINT AND FILL IN THE ENTIRE FORM.

Date: _____ (Day / Month / Year)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss

Name _____ (Last / First) **Email** _____

Mobile Phone _____

Date of birth _____ (Day / Month / Year) Age _____ Sex _____

Home Phone _____

Address _____ (Street / City / Province / State / Postal / Zip Code)

Occupation _____ Employer _____ Phone ( ) _____ Extension _____

Name of spouse or parent (if child) _____ Work phone ( ) _____

In case of emergency _____ Phone ( ) _____

Medical Physician _____ Phone ( ) _____

Medical Specialist _____ Phone ( ) _____

Referred by _____ Dental insurance Yes ☐ No ☐ _____

PRIMARY DENTAL INSURANCE

Name of insured _____ Date of birth (Day / Month / Year)

Insurance carrier _____

Group / Policy no. _____ Certificate no. _____

SECONDARY DENTAL INSURANCE

Name of insured _____ Date of birth (Day / Month / Year)

Insurance carrier _____

Group / Policy no. _____ Certificate no. _____

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand.

DENTAL HISTORY QUESTIONNAIRE

- What is the reason for your visit today ? _____
- When was your last dental visit ? What was done at that appointment? _____
- When did you last have dental x-rays? _____
- How often do you brush your teeth? How often do you floss? Do your gums bleed when you brush or floss?

_____

	YES	NOT SURE / MAYBE	NO
• Do you feel that you have bad breath?	☐	☐	☐
• Have you been seeing a dentist regularly? if not, why not ?_____	☐	☐	☐
• Have you ever seen a dental specialist?	☐	☐	☐
• Have you had a bad experience or complications during dental treatment?	☐	☐	☐
• Have you ever had an injury to the teeth or jaws or been involved in a motor vehicle accident?	☐	☐	☐
• Do you have any problems with your jaw (clicking, limited movement, pain) ?	☐	☐	☐
• Have you ever been advised to take antibiotics before dental appointments?	☐	☐	☐
• Are you happy with the appearance of your teeth?	☐	☐	☐

Medical Questionnaire

	YES	NOT SURE / MAYBE	NO
• Are you currently being treated for any medical condition or have you been treated within the past year? If yes, please explain. _____	☐	☐	☐
• When was your last medical checkup? _____			
• Has there been any change in your general health in the past year? If yes, please explain _____	☐	☐	☐
• Are you taking any medications or non-prescription drugs or herbal supplements of any kind? If yes, please list them. _____	☐	☐	☐
• Do you have any **allergies**? If yes please check and list any others. ☐ Penicilline ☐ Codeine ☐ Latex ☐ Other _____	☐	☐	☐
• Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. _____	☐	☐	☐
• Do you have or have you ever had any heart or blood pressure problems ?	☐	☐	☐
• Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis) a heart condition from birth (i.e. congenital heart disease) or a heart transplant?	☐	☐	☐
• Do you have a prosthetic or artificial joint?	☐	☐	☐
• Do you have any conditions, or therapies that could affect your immune system? (e.g. Leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)?	☐	☐	☐
• Do you have a bleeding problem or bleeding disorder ?	☐	☐	☐
• Have you ever been hospitalized for any illnesses or operation? If yes, please explain. _____	☐	☐	☐

Do you have or have you ever had any or the followings ? Please check.

☐ chest pain, angina	☐ rheumatic fever	☐ pacemaker	☐ steroid therapy	☐ seizures (epilepsy)
☐ heart attack	☐ mitral valve prolapse	☐ lung disease	☐ diabetes	☐ kidney disease
☐ stroke, TIA	☐ tuberculosis	☐ stomac ulcers	☐ thyroid disease	☐ shortness of breath
☐ heart murmur	☐ cancer	☐ arthritis	☐ drug/alcohol/ cannabis use or dependency	☐ osteoporosis medications (e.g. Fosamax, Actonel, Prolia)
☐ asthma	☐ liver disease	☐ hepatitis		

Are there any conditions or diseases not listed above that you have or have had? if yes, please explain.

_____

- Do you smoke or chew tobacco products? ☐ Yes ☐ No
- Are you pregnant? ☐ Yes ☐ No ☐ Not sure/Maybe

  If pregnant, what is the expected delivery date? _____
- Are you breastfeeding ☐ Yes ☐ No
- Do you identify as a patient with a disability? If yes, please explain. ☐ Yes ☐ No ☐ Not sure/Maybe

_____

INFORMED CONSENT / GENERAL RELEASE

I, the undersigned, state that I have provided an accurate and complete Medical/Dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding this Medical/Dental history and I consent to my physician being contacted if necessary. I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services including the use of anaesthetic as be necessary. I also understand that I assume responsability for any and all fees associated with these procedures and services.

Patient/Parent/Guardian Signature: _____ Date: _____ (Day / Month / Year)

Dentist Signature: _____ Date: _____ (Day / Month / Year)