Ordre des dentistes du Québec

Confidential and secure registration form

Patient information	**Fee manager**
Gender:	
Last name:	Last name:
First name:	First name:
Adress:	Adress:
City:	City:
Home phone:	Home phone:
Mobile phone:	Mobile phone:
Work phone:	Work phone:
Date of birth:	
Email:	

Health insurance number:
Expiry:

If you are under 18, write the name of the parent:
OR guardian:

Are you a beneficiary of a social assistance program in Quebec?
Yes No

Reffered by:

Dental history

Reason for visit:

Do you fear dental treatment? Yes No
Specify:

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Last visit:
What is the full name of the attending dentist:
Received treatment(s):

With panoramic dental radiography (large X-ray)	Yes	No
With intraoral dental radiographs (small x-rays)	Yes	No

Have you ever had dental treatments such as:

Oral hygiene demonstration	Yes	No
Gum treatment	Yes	No
Orthodontic Treatment	Yes	No
Root canal treatment	Yes	No
Shutter	Yes	No
Crown and / or bridge	Yes	No
The tonsils were they removed ?	Yes	No
Adeid (vegetations) were they removed?	Yes	No
Do you have a nasal septum deviation?	Yes	No
Do you have difficulty breathing through the nose?	Yes	No
Have you ever been hit on your teeth?	Yes	No
Do you suck your thumb or finger?	Yes	No
Complete and / or partial dentures	Yes	No
Oral surgery or extractions Treatment	Yes	No
Dental implants	Yes	No
Dental x-rays	Yes	No

Gnaw your nails yourself?	Yes	No
Do you get anyed about your teeth?	Yes	No
Do you grind your teeth at night?	Yes	No
Did you have a consultation with an orthodontist?	Yes	No

If so, which?

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Information on growth (for children 10-14 years)

Is your child in active growth period?	Yes	No
Does your child seem to have reached puberty?	Yes	No

Girls only

Have menstruation started?	Yes	No

If so, how long?

Do you take anovulants or hormones?	Yes	No

Specify:

Are you pregnant?	Yes	No
Do you breastfeed?	Yes	No

Medical history

Are you actually under a doctor's care?	Yes	No

If so, reason:

Doctor's name:
Doctor's phone:

Are you taking natural or homeopathic products?	Yes	No
Are you currently taking medications?	Yes	No
Have you taken or lost a lot of weight lately?	Yes	No
Would you like to discuss your health with your dentist in private?	Yes	No
Have you ever been operated on or hospitalized?	Yes	No
Do you take anovulants or hormones?	Yes	No

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Have you suffered or are you suffering from :

Cardiac disorders (heart attack, angina, valve problems, breath)	Yes	No
Rheumatic fever	Yes	No
Pain in the jaw joint	Yes	No
Dryness of the mouth	Yes	No
Blood problems:		
Haemophilia	Yes	No
Prolonged bleeding	Yes	No
Bright blood	Yes	No
Blood pressure (high or low)	Yes	No
Anemia	Yes	No
Other, specify		
Frequent colds or sinusitis	Yes	No
Pulmonary tuberculosis or problems	Yes	No
Digestive disorders	Yes	No
Specify :		
Stomach ulcer	Yes	No
Liver problems (hepatitis: viruses A, B, C, etc.)	Yes	No
Kidney disorders	Yes	No
Urinate you often?	Yes	No
Sexually transmitted diseases (STDs)	Yes	No
Specify:		
Diabetes	Yes	No
Thyroid disorders	Yes	No
Skin diseases	Yes	No
Chronic Pain	Yes	No
Eye problems	Yes	No
Do you take bisphosphonates?	Yes	No
Epilepsy	Yes	No
Nervous disorders	Yes	No

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	Yes	No
Psychiatric diseases	Yes	No

Specify:

Dizziness, fainting	Yes	No
Earaches	Yes	No
Hay fever	Yes	No
Asthma	Yes	No
Arthritis	Yes	No
Osteoporosis	Yes	No

Have you ever had radiation treatment and/or chemotherapy (tumor) ?	Yes	No
Do you have any artificial joints (hip, knee, etc.)?	Yes	No

Have you ever had an allergic reaction or other to the following products :

Latex	Yes	No
Foodstuffs	Yes	No
Iodine	Yes	No
Aspirin	Yes	No
Sulfonamides	Yes	No
Penicillin	Yes	No
Codeine	Yes	No
Other antibiotics	Yes	No
Local anesthesia	Yes	No
Other, specify		

Other aspects

Do you sore or does one ever told you that you sore?	Yes	No
Do you suffer from sleep apnea?	Yes	No
Do you smoke?	Yes	No
Do you use drugs?	Yes	No
Do you consume alcohol?	Yes	No
Do you take methadone?	Yes	No

Notes or other medical conditions to mention:

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Operative Precautions - For the use of the professional

Consent to communicate with a health professional

To be completed by the patient

I, the undersigned, declare that I have read, understood, inquired and answered the forensic questionnaire above to the best of my knowledge. I hereby agree to notify you of any change in my state of health. I authorize the constitution of my dental file, its follow-up as well as my inscription on the recall list of the dentist (s) treating (s). I have been informed that my dental record will be kept in the office at all times and that the dentist (s) and his / her auxiliary staff will have (only) access. I was also informed of my right to consult my file, to request a correction and to withdraw from the recall list.

Date (dd/mm/yyyy) :
Signature of patient or manager:____

For dentist

I have read the answers to the registration questionnaire and taking the usual measures as appropriate.

Date (dd/mm/yyyy) :
Signature of the treating dentist:____________________________