DR. GENEVIÈVE AUDET + ASSOCIÉS

CONFIDENTIAL NEW PATIENT FORM

PLEASE PRINT, FILL IN AND BRING TO YOUR NEXT VISIT

NEW PATIENT INFORMATION

Sex: ☐ M ☐ F Last Name: _____ First Name: _____

Address: _____
Street City Province Postal Code

Home Phone#: ( )_____ Cell#: ( ) _____

Date of Birth: D ____ MM _____ Year _____ Marital Status _____Weight ____ Height _____

Email: _____

Guardian: _____

Referred By: _____

Reason For Visit: _____

NEW PATIENT MEDICAL HISTORY

PHYSICIAN(S) INFORMATION

1. Your current physician:
   Name:_____Phone: ( )_____
2. Are you presently taking any drugs or medication, or have you taken any in the last 6 months?
   _____
   _____
3. Are you pregnant? ☐ Y ☐ N
4. Are you taking any birth control pills? ☐ Y ☐ N

Are you suffering or have you ever suffered from…. ? Check the box:

5. ☐ Heart Disease (stroke, angina, murmur, valvular problems)
6. ☐ Rheumatic Fever
7. ☐ Prolonged Bleeding
8. ☐ Anemia
9. ☐ Blood Pressure Issues ☐ High ☐ Low
10. ☐ Frequent colds or sinusitis
11. ☐ Tuberculosis or lung problems
12. ☐ Digestive problems
13. ☐ Stomach Ulcers
14. ☐ Liver Disease (hepatitis A, B, C, cirrhosis, etc)
15. ☐ Kidney Disease

16. ☐ Venereal Disease (STD)
17. ☐ Diabetes
18. ☐ Thyroid problems
19. ☐ Skin disease
20. ☐ Eye problems
21. ☐ Arthritis
22. ☐ Epilepsy
23. ☐ Nervous Disorders
24. ☐ Frequent Disorders
25. ☐ Dizzy spells and/or fainting spells
26. ☐ Earaches
27. ☐ Hayfever
28. ☐ Asthma
29. Do you smoke? ☐Y ☐ N
30. ☐ Have you ever had radiotherapy and/or chemotherapy treatments (tumor)?
31. ☐ Do you carry the AIDS virus?
32. ☐ Do you have AIDS symptoms?
33. ☐ Do you have artificial joints? (knee, hip, etc)

34. Do you have any of the following allergies? Please check boxes below:

☐ Penicillin
☐ Aspirin
☐ Iodine
☐ Other _____
☐ Food _____

☐ Sulfonamides
☐ Codeine
☐ Local Anesthesia

35. Were you ever hospitalized or have you undergone surgery other than dental? If so, indicate which ones and what?

_____

_____

36. Is there anything concerning your health that you wish to discuss privately with your dentist?

_____

_____

FOR PHYSICIAN USE ONLY: MEDICAL ALERT!

DENTAL HISTORY

Last Dental Visit: ☐ 0-6 months ☐ 6-12 months ☐ >12 months

Treatments received: _____

Did you previously have dental treatments such as:

☐ Oral hygiene instruction

☐ Orthodontic Treatments

☐ Root Canal Treatment

☐ Dental Fillings

☐ Crown and/or bridge

☐ Partial and/or complete denture

☐ Surgical treatments or extraction

☐ Dental implants

☐ X-rays

☐ Other _____

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 changes 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 treating dentist(s).

I acknowledge that I have read the answers to the above questionnaire and that I have taken the customary measures.

X_____ _____ _____/_____/_____
Patient of Guardian Date Signed

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.

X_____ _____ _____/_____/_____
Attending Dentist Date Signed