

## CONFIDENTIAL INTRODUCTORY QUESTIONNAIRE

Surname: _____	Date of first appointment: _____
Name: _____	Sex: F <input type="checkbox"/> M <input type="checkbox"/> Referred by: _____
How can we help you? _____ _____ _____	
Please initial: _____	
When did you last see your dentist: _____	
Date of your last dental cleaning? _____	
Why do you consider leaving your previous dentist? _____	
Do you have special requests for dental treatment? _____	

<b>DENTAL HISTORY</b>		yes	no
Have you had a thorough dental examination with x-rays in the past 2 years?		<input type="checkbox"/>	<input type="checkbox"/>
Are any of your teeth sensitive to:	sweets?	<input type="checkbox"/>	<input type="checkbox"/>
	heat?	<input type="checkbox"/>	<input type="checkbox"/>
	cold?	<input type="checkbox"/>	<input type="checkbox"/>
	Pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any areas where food gets stuck between your teeth?		<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from ulcers in the mouth?		<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed?		<input type="checkbox"/>	<input type="checkbox"/>
Are your gums swollen?		<input type="checkbox"/>	<input type="checkbox"/>
Do you have breath problems?		<input type="checkbox"/>	<input type="checkbox"/>
How often do you brush your teeth? _____	Floss? _____		
With an electric? _____	or manual toothbrush? _____		

Do you grind or clench your teeth:	at night? <input type="checkbox"/> <input type="checkbox"/>
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"	"	during the day?	<input type="checkbox"/>	<input type="checkbox"/>
Do your jaws feel tense or tender?			<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from headaches or migraines?			<input type="checkbox"/>	<input type="checkbox"/>
Upon awakening?			<input type="checkbox"/>	<input type="checkbox"/>
Does your jaw crack on opening or closing?			<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from:	neck pain?		<input type="checkbox"/>	<input type="checkbox"/>
	back pain?		<input type="checkbox"/>	<input type="checkbox"/>
	shoulder pain?		<input type="checkbox"/>	<input type="checkbox"/>
	earaches?		<input type="checkbox"/>	<input type="checkbox"/>
Have you had:	orthodontic braces?		<input type="checkbox"/>	<input type="checkbox"/>
	gum treatment?		<input type="checkbox"/>	<input type="checkbox"/>
	root canal treatment?		<input type="checkbox"/>	<input type="checkbox"/>
	crowns or bridges?		<input type="checkbox"/>	<input type="checkbox"/>

### MEDICAL HISTORY

	YES	NO
Have you noticed health problems following dental care?	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from multiple allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Do you undergo an annual medical check-up?	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>
For what reason? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you take any:		
medication?	<input type="checkbox"/>	<input type="checkbox"/>
birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>
vitamins?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>

Are you allergic to certain medications?		
penicillin?	<input type="checkbox"/>	<input type="checkbox"/>
iodine?	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin?	<input type="checkbox"/>	<input type="checkbox"/>

	local anesthetic?	<input type="checkbox"/>	<input type="checkbox"/>
	latex?	<input type="checkbox"/>	<input type="checkbox"/>
	other?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been hospitalized?		<input type="checkbox"/>	<input type="checkbox"/>
What is your blood type ?		_____	
Are you pregnant?	Due date? ____/____/____		
Have you had X-rays in the past 6 months? (dental or other)		<input type="checkbox"/>	<input type="checkbox"/>
Have you had radiotherapy (for cancer)?		<input type="checkbox"/>	<input type="checkbox"/>

Do you suffer or have you ever suffered from:

	yes	no		yes	no
respiratory problems?	_____	_____	anaemia ?	_____	_____
sinusitis?	_____	_____	diabetes ?	_____	_____
bronchitis?	_____	_____	arthritis ?	_____	_____
pneumonia?	_____	_____	unconsciousness ?	_____	_____
heart related problems?	_____	_____	cancer ?	_____	_____
hypertension?	_____	_____	epilepsy ?	_____	_____
thyroid problems?	_____	_____	kidney ailments ?	_____	_____
auditory problems?	_____	_____	digestive problems ?	_____	_____
ear problems?	_____	_____	hepatitis or jaundice ?	_____	_____
rheumatic fever?	_____	_____	venereal disease ?	_____	_____
skin disorders?	_____	_____	AIDS?	_____	_____
genital disease?	_____	_____			

**Smile analysis**

	Yes	No
Are you reluctant to show your teeth when you smile?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any gaps or spaces between your teeth which you are concerned about or would like to change?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any stains on your teeth which you would like removed or		

lightened?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any chipped or broken teeth which you are concerned about or would like to change?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any teeth that are crooked or misaligned which you are concerned about or would like to change?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to have whiter teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are you satisfied with the <u>appearance</u> of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
If you had a magic wand what would you change in your <u>smile</u> ?		

Please inform us of any serious health problem: \_\_\_\_\_  
 \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_  
 Phone number: \_\_\_\_\_

I confirm that the above information is correct and accept that Dr. Pierre Larose and his staff proceed to a complete examination of my mouth, including necessary X-rays. I have been informed that my dental chart will be kept in the office at all times and that only the dentist and his staff will have access to it. I may consult my chart and request modifications at any time. I am consulting Dr. Larose for my dental health exclusively. I have been advised to seek medical advice from a physician for any general health problem I may have. I hereby authorize doctor Larose to contact my personal physician:

Dr. \_\_\_\_\_ Address: \_\_\_\_\_

Nothing doctor Larose or his staff say must be interpreted as a promise that my general health will be improved in any way as a result of treatment rendered. I understand I will not be charged for a first missed or cancelled appointment but will be billed a \$50. broken appointment fee for any further broken appointments during that year.

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 day month year

Signature: \_\_\_\_\_