There anyCONFIDENTIAL INTRODUCTORY QUESTIONNAIRE

750 BOUL. MARCEL-LAURIN #100, SAINT-LAURENT, QC, H4M 2M4
TÉL. 514.747.4949 COURRIEL : info@sourirelarose.com

GÉNÉRAL

Date of 1th visit :		File # :
Family name :	First name :	
Date of birth :	Âge :	Sexe : M F
Address :		
City :	Province :	Postal code :
Tel. (home) :	Tel. (work) :	
Cellular :	E-mail :	
Occupation :	Referred by :	
Reason for your visit : _____ _____ _____		
Why did you choose *Santé Dentaire Larose*?		
Do you have any specific requests concerning your appointments with us?		
Are there any changes you are considering undertaking in your mouth?		

PERSON TO CONTACT IN CASE OF EMERGENCY

Name :	Relationship :
Tel. (home)	Cell. / Work :

OTHER HEALTH PROFESSIONALS

1.	2.
Specialty :	Specialty
Tel.	Tel.

DENTAL HISTORY

When was your last dental appointment?

		Yes	No
Have you had a complete dental examination with x-rays in the last 2 years?			
Are your teeth sensitive to:	heat		
	cold		
	sweets		
	pressure		
Do you sometimes feel electric shocks to the teeth?			
Are there one or more places where food often gets stuck between your teeth?			
Do you often have cankers sores in your mouth?			
Do you have bad breath?			
What toothbrush do you use? :	manual		
Frequency:	electric		
How often do you floss?			
How often do you have your teeth cleaned at the dentist?			
Date of your last professionnal cleaning?			
Do you grind or clench your teeth?			
Do your jaws feel tense?			
Do you suffer from headaches or migraines?			
Headaches or migraines upon awaking?			
Does your jaw crack on opening or closing?			
Do you suffer from :	neck pain		
	shoulder pain		
	earaches		
	back pain		
Have you had :	orthodontic braces		
	gum treatment		
	root canal treatment		
	crowns or bridges		
	implants		
	general anesthesia		

MEDICAL HISTORY

		Yes	No
Have you noticde health problems following dental care? If so, describe? :			
Do you see a doctor for a specific problem?			
Do you see a doctor for an annual checkup?			
Are you pregnant? if so, due date :			
What medications are you taking?			
What dietary supplements (vitamins, etc.) do you take?			
Do you take birth control pills?			
Do you smoke? How many cigarettes per day :			
Have you ever received radiotherapy (cancer)? Date :			
Are you allergic to any medications or products?	Penicillin		
	Iodine		
	Local anesthesia		
	Latex		
Other drug allergies? (specify) :			

DO YOU SUFFER OR HAVE YOU EVER SUFFERED FROM

	Yes	No		Yes	No
Respiratory problems			Diabetes		
Sinusitis			Migraines		
Bronchitis			Fibromyalgia		
Asthma			Depression If yes, when was the diagnosis:		
			Seasonnal depression		
Pneumonia			Rheumatic fever		
Heart related problems			Anaemia		
Thyroid problems			Epilepsy		
Hypertension			Digestive problems		

	Yes	No		Yes	No
Auditory problems			Candida		
Ear problems			Kidney aliments		
Cancer			Multiple sclerosis		
Venereal disease			Snoring		
Genital herpes			Other diagnoses or problems:		
AIDS					

SMILE ANALYSIS

Are you reluctant to show your teeth when you smile?		
Do you have spaces between teeth that concern you or that you would eliminate?		
Do you have stains on your teeth that you would remove or bleach?		
Have you broken teeth that concern you or that you would like to improve?		
Do you have teeth that are crooked or misaligned that worry you or you would like to improve?		
Would you like to have whiter teeth?		

What would you change in your smile if you had a magic wand?

I confirm that the above information is correct and accept that Dr. 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 Dr. Larose to contact my personal physician:

Dr._____ Address:_____

Nothing Dr.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 $50.00 broken appointment fee for any further broken appointment during that year.

Signature : _____ Date : _____/_____/_____

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