Insurance Information (if applicable)

Plan Contract No. _____
Certificate No. _____
Policy No. _____
ID No. _____

Name of policy holder:_____
Relationship to policy holder: ❒ self ❒ spouse ❒ parent

Please mention any secondary insurance you may have.

Informed Consent

I acknowledge that I filled out this medical questionnaire to the best of my ability, and that all of the information provided is true and accurate.

I consent to having all necessary or desirable dental treatments performed by Dr. Seminara or his staff after being informed of all of my options and potential side effects. I also assume the responsibility of paying the fees associated with these treatments.

Signature _____

Date _____

CLINIQUE DMD
DOWNTOWN MONTREAL DENTISTRY

Patient Dental and Medical Record

Family Name:_____ Name:_____

Address:_____

City:_____ Province:_____

Postal Code:_____ Date of Birth ____/____/___

Telephone: Home: _____ Work: _____

Mobile:_____ Email:_____

Preferred Contact Method: ❒ Mobile ❒ Work ❒ Home ❒ Email

Employer:_____

Job Title: _____

Do you have dental insurance? ❒ Yes ❒ No

Insurance Company:_____

Are you a student? ❒ Yes ❒ No Level:_____

School:_____

Spouse's Name (If applicable):_____

Name of Family Doctor: _____

What is the reason for today's visit? _____

Who may we thank for referring you?_____

Mission Statement
Our team is committed to providing exceptional dental care in a compassionate and caring environment

Confidential Health Questionnaire

Are you currently seeing a doctor for any reason? ❒ Yes ❒ No

If yes, why?_____

Are you taking any medication or drugs of any kind? ❒ Yes ❒ No

Please list or attach list:_____

Do you have any allergies to medications or other? ❒ Yes ❒ No

Please specify: _____

Have you been hospitalized in the last five years for any reason? If yes, why? ❒ Yes ❒ No

_____

Do you bleed excessively when you injure yourself? ❒ Yes ❒ No

Do you have any artificial joints or heart valves? ❒ Yes ❒ No

Are you pregnant? ❒ Yes ❒ No How many weeks?_____
Do you smoke? ❒ Yes ❒ No How many per day?_____
Use recreational drugs? ❒ Yes ❒ No _____

Do you currently, or have ever, suffered from any of the following? Please check all that apply:

❒ Anemia
❒ Angina
❒ Arthritis
❒ Asthma
❒ Cancer
❒ Diabetes
❒ Epilepsy
❒ HIV / AIDS
❒ Heart problems
❒ Hepatitis
❒ Kidney problems
❒ Liver problems
❒ Lung / breathing problems
❒ Psychiatric disorders
❒ Rheumatic fever
❒ Sexually transmitted disease
❒ Stomach or intestinal problems
❒ Stroke

Any other illness / conditions not yet mentioned?

_____
_____
_____

Dental History

How long since your last dental visit? _____

Name of previous dentist: _____

Are you nervous about visiting the dentist? ❒ Yes ❒ No

What bothers you most about visiting the dentist? _____

What can we do to make your visit more pleasant? _____

How often do you brush your teeth? _____ Floss?_____

Do your gums bleed when you brush or floss? ❒ Yes ❒ No

Are your teeth sensitive to cold? ❒ Yes ❒ No

Have you had any of the following treatments?

❒ Extractions
❒ Gum treatments
❒ Orthodontics
❒ Root Canals
❒ Implants
❒ Oral Surgery

Are you satisfied with the appearance of your teeth? ❒ Yes ❒ No

Are you satisfied with the function of your teeth? ❒ Yes ❒ No

If you could, how would you improve the appearance of your teeth?

_____

Are there any questions you would like to have answered?

_____

For doctor's use