Mancini

Parodontie et Implantologie

PATIENT INFORMATION

Last Name _____ First Name _____ Date of Birth: Day____ Month_____ Year_____

Occupation_____

Home phone _____ Cell Phone_____ Work phone _____

Which is more convenient for you to be contacted? ☐ Work Phone ☐ Home Phone ☐ Cell Phone

E-mail Address_____

Home address _____ City _____ Postal Code _____

Person to Contact in Case of Emergency _____ Telephone _____

Whom may we thank for referring you to our office? _____

Are you covered by dental insurance? ☐ Yes ☐ No

Medical Health History

1) Are you in good health?_____

2) Are you presently under the care of a physician? ☐ Yes ☐ No
If so, give reason(s) for treatment: _____

3) Are you taking any kind of medication (prescribed or non-prescribed)? if so, give name:
_____

4) Do you have or have you had any of the following?
(Please check any that apply)

- ☐ Allergies. If yes, please specify: _____
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Heart trouble
- ☐ High or low blood pressure
- ☐ Anemia
- ☐ Ulcers
- ☐ Respiratory Problem
- ☐ Sexually Transmitted Infection (STI's)
- ☐ Asthma
- ☐ Sinusitis
- ☐ Mental illness
- ☐ Migraine
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Liver disease
- ☐ Hepatitis/jaundice
- ☐ Alcoholism
- ☐ Aids/HIV
- ☐ Prosthetic joint
- ☐ Articular problem
- ☐ Other: _____

Do you smoke? ☐ Yes ☐ No

PLEASE COMPLETE THE FORM ON THE FOLLOWING PAGE

5) Have you ever had any trouble with prolonged bleeding? _____

6) Have you ever had an unusual reaction to an anesthetic? ☐ Yes ☐ No

If yes, please explain: _____

7) Have you ever had an unusual reaction to any medication? ☐ Yes ☐ No

If yes, please explain: _____

8) Is there any information that should be known about your health?

_____

9) If female, are you pregnant? ☐ Yes ☐ No

Dental History

Last Visit: ☐ 0-6 months ☐ 6-12 months ☐ 12 months +

Have you previously had any of the following dental treatments? (Please check all that apply)

☐ Oral hygiene instructions
☐ Gum treatment
☐ Orthodontic treatment
☐ Root canal treatment
☐ Dental fillings
☐ Crown and/or bridge
☐ Partial and/or complete denture
☐ Surgical treatment or extraction
☐ Dental implants
☐ X-Rays
☐ Others: _____

Mailing List

☐ I would like to receive information concerning possible company relocation, change in opening hours, dental & health advice, as well as any other important updates.

DATE _____ SIGNATURE _____

SEND BY EMAIL