Harrisville
dental dentaire

1121 Shediac Rd., Moncton, NB E1A 7B6
Tél./Tel: (506)858-0188
info@harrisvilledental.ca

Name ____________________ Date of birth ____________

Address ____________________ TEL.(res.) ____________

City ____________________ TEL. (work) ____________

Postal Code ____________________ TEL. (cell) ____________

Dental Insurance Yes ☐ No ☐ Occupation ____________

Medical Doctor ____________

Communication: Address ____________

Cell text ☐ Work ☐ TEL. ____________

Home phone ☐ Email ☐ Email ____________

Medical History

	Yes	No
1. Are you presently under treatment by a physician?	☐	☐

Physician telephone: ____________

Surname: ____________ Given Names: ____________

	Yes	No
2. Are you taking any drugs or medications, or have you taken any during the last six months?	☐	☐

Are you suffering or have you ever suffered from:

	Yes	No
3. Heart problems	☐	☐
4.Rheumatic fever	☐	☐
5. Prolonged bleeding	☐	☐
6. Anemia	☐	☐
7. High/ low blood pressure	☐	☐
8. Frequent colds or sinusitis	☐	☐
9. Tuberculosis or pulmonary problems (breathing)	☐	☐
10. Problems of digestion (stomach)	☐	☐
11. Liver disease (hepatitis, cirrhosis, etc.)	☐	☐
12. Kidney disease	☐	☐
13. Human papillomavirus (HPV)	☐	☐
14. Diabetes	☐	☐
15. Thyroid problems	☐	☐
16. Skin disorders	☐	☐
17. Visual disorders (eye)	☐	☐
18. Arthritis	☐	☐
19. Epilepsy	☐	☐
20. Nervous disorders	☐	☐
21. Frequent headaches	☐	☐
22. Fainting spells	☐	☐
23. Earaches	☐	☐
24. Have you ever undergone radiotherapy treatments? (tumor)	☐	☐
25. Are you pregnant?	☐	☐
26. HIV / AIDS	☐	☐

Dental History

Last examination:

- 0-6 m ☐
- 6m-1yr ☐
- 1+yr ☐

Reason for today's visit :

- Emergency only ☐
- Specific examination ☐
- Complete examination ☐

Have you ever been hospitalized or undergone surgery? If yes, list and indicate approximate dates.

	year

Remarks: ____________

	Yes	No
27. Do you have any allergies?	☐	☐

Hay fever	☐	Iodine	☐
Asthma	☐	Sulfonamides	☐
Penicillin	☐	Local Anesthesia	☐
Aspirin	☐	Others	☐

I, the undersigned hereby declare, to have read, understood and answered the above medico-dental questionnaire to the best of my knowledge. I accept the dental treatments assigned by the treating dentist.

Signature: ____________

Date: ____________