MONTRÉAL
MAXILLO-FACIAL

CONFIDENTIAL REGISTRATION FORM

PERSONAL INFORMATION

Last Name _____ Given Name _____ Phone (Home) _____

Date of birth ____ / ____ / ____ (M / D / Y) Sex ☐ M ☐ F ☐ X Phone (Work) _____ # _____

Address _____ Mobile _____

City _____ Postal Code _____ Email _____

Do you have **dental insurance** ? ☐ Yes ☐ No

Do you receive **social assistance (welfare)** ? ☐ Yes ☐ No

PREFERRED MODALITY OF COMMUNICATION:

☐ Email ☐ Text message ☐ Telephone

Reason for visit _____

Name of your dentist _____ Who referred you to our o ce? _____

MEDICAL INFORMATION

Height _____ Weight _____

Have you ever been hospitalized or had an operation? ☐ Yes ☐ No Explanation _____

Do you smoke tobacco? ☐ Yes ☐ No
How often? _____

Do you drink alcohol? ☐ Yes ☐ No
How often? _____

Do you use cannabis products? ☐ Yes ☐ No
How often? _____

Do you use illicit drugs? ☐ Yes ☐ No
Which kind? _____

HAVE YOU EVER HAD OR ARE BEING TREATED FOR THE FOLLOWING?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	Gastrointestinal Disorder	☐	☐	HIV or AIDS	☐	☐	Tendency to Faint
☐	☐	Cancer	☐	☐	Heart Disease	☐	☐	Kidney Disease	☐	☐	Thyroid Disease
☐	☐	Diabete	☐	☐	Hepatitis A, B or C	☐	☐	Liver Disease			
☐	☐	Epilepsy	☐	☐	High Blood Pressure	☐	☐	Osteoporosis			

WOMEN ONLY

Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

ALLERGIES, MEDICATION AND OTHER INFORMATION

Are you allergic to, or have ever had an unusual reaction to any of the following?

Yes	No		Yes	No	
☐	☐	General Anaesthesia	☐	☐	Penicillin
☐	☐	Dental Injections	☐	☐	Latex
☐	☐	Codeine			

Other

Please list any medications you are presently taking

Do you wish to add any other information with regard to your general health status?

How can we make your care more pleasant?

Name or signature of the patient/responsible party _____ Date ____ / ____ / ____ (M / D / Y)

Relation to patient if other _____