MONTRÉAL
MAXILLO-FACIAL

CONFIDENTIAL REGISTRATION FORM

PERSONAL INFORMATION

Last Name _____ Given Name _____ Phone (Home) _____

Date of birth ____ (M) / ____ (D) / ____ (Y) Sex ☐ M ☐ F 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 ☐ iMessage ☐ Telephone

MEDICAL INFORMATION

Reason for visit _____

Who referred you to our office? _____

Name of your dentist _____ Name of your physician _____

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

Are you presently taking any homeopathic medication? ☐ Yes ☐ No

Do you smoke tobacco? ☐ Yes ☐ No

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

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

Do you use illicit drugs? ☐ Yes ☐ No

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

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

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

Please list any medications you are presently taking

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

Is there additional information you wish to share to help us make your care more pleasant?

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

Relation to patient if other _____