



DR. LUC DUCHARME  
& ASSOCIATES

# WELCOME TO OUR OFFICE

Date: \_\_\_\_\_  
Month / Day / Year

## Patient Registration

**All Information is Confidential**

The following information is required by the dentist to assist in proper diagnosis and treatment.  
Please feel free to ask receptionist for help in completing this form. PLEASE PRINT.

Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_  Dr.  Mr.  Mrs.  Ms  Miss

Address \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ Province / State \_\_\_\_\_ Postal / Zip Code

Date of birth \_\_\_\_\_ Month / Day / Year Age \_\_\_\_\_ Sex \_\_\_\_\_ Home phone ( \_\_\_\_\_ ) \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Extension

Referred by \_\_\_\_\_

Name of spouse or parent (if child) \_\_\_\_\_ Work phone ( \_\_\_\_\_ ) \_\_\_\_\_

Family physician \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

In case of emergency \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Dental insurance Yes  No  Person responsible for account \_\_\_\_\_

PRIMARY DENTAL INSURANCE		SECONDARY DENTAL INSURANCE	
Name of insured	Date of birth	Name of insured	Date of birth
_____	_____ <small>Month / Day / Year</small>	_____	_____ <small>Month / Day / Year</small>
Employer _____		Employer _____	
Insurance carrier _____		Insurance carrier _____	
Group / Policy no. _____ Certificate no. _____		Group / Policy no. _____ Certificate no. _____	

In order to provide safe dental care for our patients, we are asking you to fill out the following questionnaires. Please answer the questions as accurately as you can. If you have any questions or doubts, check the NOT SURE / MAYBE choice. Your responses will be reviewed with you by the dentist. You can be assured that the information that you provide will be kept in the strictest confidence.

### DENTAL HISTORY QUESTIONNAIRE

- When was your last dental visits? \_\_\_\_\_
- When did you last have dental x-rays? \_\_\_\_\_
- How often do you brush your teeth? \_\_\_\_\_
- How often do you floss your teeth? \_\_\_\_\_

- |  | YES                      | NOT SURE / MAYBE         | NO                       |
|--|--------------------------|--------------------------|--------------------------|
| • Have you been seeing a dentist regularly?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do any of your teeth ache?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Have you ever been advised to take antibiotics before dental appointments?                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do your gums bleed when you brush?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you have any pain when you chew?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Do you feel that you have bad breath?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Have you ever been in a vehicle accident or experienced any blows to your jaw?                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Have you ever had any implant surgery in one or both of your jaws or jaw joints?                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • If you answered <b>YES</b> to the last question, who performed the surgery and when was it done? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Are you being followed-up by a dental specialist? _____  |                          |                          |                          |
| • Please list anything else not mentioned above regarding your past dental history: _____                |                          |                          |                          |

