clinique dentaire du versant

Dre Caroline Côté
chirurgienne dentiste

720, Montée Paiement, suite 100
Gatineau (Québec), J8R 4A3
f. 819.669.8181

t. 819.669.4666

File# ☐

Confidential

Last name : _____ First name : _____

Address : _____
No Street App. City Postal code

Telephone home: _____ ☐ Work: _____ext.____ ☐ Cell: _____ ☐

E-mail: _____ ☐ **Indicate your preference in the way we contact you.**

Date of birth : ___/___/___ Health card # : _____ Exp : _____

Social insurance # : _____ Driver licence # : _____

Employer : _____ Occupation : _____

Spouse name : _____ Parent(s) name /legal guardian: _____

How did you hear about us/who referred you? :_____

Primary insurance : _____
Owner : _____ Date of birth : ___/___/___
Employer : _____
Police # : _____ ID/Certificat #: _____ Social insurance # : _____

Secondary insurance: _____
Owner :_____ Date of birth: ___/___/___
Employer : _____
Police # : _____ ID/Certificat #: _____ Social insurance # : _____

Responsible of the account: Myself☐ Spouse ☐ Parent☐ : _____

Dental insurance politics: Dental insurance are a financial aid that you subscribe to. You are responsible for the entire amount that is bill to you. It is your responsibility to know your insurance politics, it will be our pleasure to guide you through this learning process. We offer to send your reclamation electronically so it will be process more efficiently for you.

Signature: _____ Date: _____

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Authorization related to dental insurance

Authorization for the electronic transmission off insurance claim

I, hereby, authorize the exchange of electronic information contained in my insurance claim to my insurance company/plan administrator. I also authorize the communication or information related to the coverage of services to my dentist. This authorization is valid as of the date it is signed, at all times, until it is revoke by the undersign.

Patient signature/parent: _____ Date: _____

Payment delegation

I, hereby, assign my benefits payable from my insurance claim to Dre. Caroline Côté and authorize payment directly to her. This authorization is valid as of the date it is signed, at all times, until it is revoke by the undersign.

Patient signature/parent: _____ Date: _____

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For the physician's use only

CONFIDENTIAL MEDICO-DENTAL QUESTIONNAIRE **File # : _____**

The dental file is constituted as part of the dental care that will be provided; it is protected by law and professional secrecy. It is kept in the office and only the dentist and his staff have access to it. The patient is also entitled to access and rectification.

This questionnaire will allow the dentist and his staff to provide the best possible care and reduce the risk of medical complications. It is in the patient's interest to respond carefully and to advise the dentist of any change in his or her health.

Medical History	**Yes**	**No**	**Reason, details, date**
1. Would you like to discuss in private with the dentist?	☐	☐	
2. Are you presently under a doctor's care?	☐	☐	_____
3. Were you ever hospitalized or have you undergone surgery?	☐	☐	_____
4. Do you have artificial joints (Knee…)?	☐	☐	_____
5. Did you recently experience a significant weight loss or gain?	☐	☐	_____
6. Are you pregnant?	☐	☐	_____
7. Are you breastfeeding ?	☐	☐	
8. Do you take natural or homeopathic products?	☐	☐	Specify _____
9. Are you taking the birth control pill ☐ or hormone ☐?	☐	☐	
10. Are you presently taking any drug medication, or did you take any in the last 12 months?	☐	☐	

Please provide us your list of medications printed by your pharmacist or specify here below (including birth control and hormones)

Medication and reason	Medication and reason

Actual or past conditions

	Yes	No
Blood problem (hemophilia, anemia, prolonged bleeding) …….	☐	☐
Heart condition: heart murmur: Functional/non-functional	☐	☐
Stroke, angina, surgery. …….	☐	☐
Heart infection (endocarditis) …….	☐	☐
Surgery to install or repair valve …….	☐	☐
Blood pressure high ☐ low ☐ …….	☐	☐
Dizzy spells or fainting spells……	☐	☐
Frequent headaches …….	☐	☐
Pain in the jaw joint …….	☐	☐
Liver problem (hepatitis A, B, C, cirrhosis, etc.) …….	☐	☐
Trouble or diseases of the digestive system …….	☐	☐
Specify_____		
Stomach problem ulcer ☐ gastric reflux ☐ …….	☐	☐
Kidney disease …….	☐	☐
Diabetes …….	☐	☐
Thyroid problem hyperthyroidism ☐ hypothyroidism ☐ …….	☐	☐
Cancer (tumor) Specify _____ …….	☐	☐
Radiotherapy …….	☐	☐
Chemotherapy …….	☐	☐
Do you suffer from dry mouth? …….	☐	☐
Sexually transmitted infection …….	☐	☐
Specify _____		

	Yes	No
Skin disease …….	☐	☐
Eyes problems …….	☐	☐
Earaches …….	☐	☐
Arthritis …….	☐	☐
Osteoporosis …….	☐	☐
Prevention treatment (medication)	☐	☐
Injection annual monthly	☐	☐
Chronic pain …….	☐	☐
Epilepsy …….	☐	☐
Troubles or disease of the nervous system	☐	☐
Troubles or psychiatric disease……	☐	☐
Frequent cold or sinusitis ……	☐	☐
Tuberculosis or pulmonary condition …	☐	☐
Asthma …….	☐	☐
Seasonal allergy / hay fever …….	☐	☐
Allergic reaction or reaction to the following	☐	☐

Latex	☐	Codeine	☐
Food	☐	Sulfonamide	☐
Iodine	☐	Penicillin	☐
Aspirin	☐	Anesthesia	☐

Other: _____

Other medical condition: _____

Other question

	Yes	No
Do you snore? …….	☐	☐
Do you suffer from sleeping apnea? …….	☐	☐
Do you smoke? ____cig. /day or ex-smoker …….	☐	☐
Do you consume alcohol ? …….	☐	☐
Frequency: ____glass ☐/Day ☐/week ☐/month		
Do you consume drug? …….	☐	☐

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CONFIDENTIAL MEDICO-DENTAL QUESTIONNAIRE **File # : _____**

Dental history

Last visit 0-6 months □ 6-12 months □ +de 12 months □ Treatment received: _____

Avez-vous déjà eu des traitements tels que

		Yes	No		Yes	No
1.	Oral hygiene instruction?	□	□	7. Partial or complete denture?	□	□
2.	Gum treatment?	□	□	8. Surgery?	□	□
3.	Orthodontic treatment ?	□	□	9. Extraction?	□	□
4.	Root canal?	□	□	10. Dental implant?	□	□
5.	Filling?	□	□	11. X-ray?	□	□
6.	Crown or bridge?	□	□	12. Others : _____		

Consent to communicate with a health professional

Family doctor : _____/_____/_____
Name Fonction Institution/ phone number

Specialist : _____/_____/_____
Name Fonction Institution/ phone number

Pharmacist : _____/_____/_____
Name Fonction Institution/ phone number

I consent that the dentist or his staff could collect, receive and exchange relevant information from these professional listed above.

_____
Patient signature Date dd/mm/yyyy

Identification

I completed this health questionnaire to the best of my knowledge.

_____
Patient signature Date dd/mm/yyyy

M.□ Mme □ _____
Name

Patient □
Parent/tutor □
Responsable □

Update

Date	Change	prof initials / patient initials
Date	Change	prof initials / patient initials
Date	Change	prof initials / patient initials
Date	Change	prof initials / patient initials

For the attending dentist

I acknowledge that I have read the answers to the above questionnaire and that I have taken appropriate measures, as the case may be.

_____
Attending dentist Date dd/mm/yyyy

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Notice to all patients of Clinique Dentaire du Versant

Policy on canceled or missed appointments

To offer quality services, we need your cooperation.

We ask you to notify us **48 hours in advance of any changes in your appointment**. This notice allows us to offer this time to another patient and allows the dentist and her team to reorganize their schedule without being penalized by your absence. If not, a **$ 40 cancellation fee** may be charged and required to be paid before your next appointment.

It is important to note that after **2 missed appointments**, your attending dentist will judge the relevance of offering you another appointment.

Thank you for **respecting your commitment** and our team of specialists in oral health.

Thank you for your understanding.

The Dental Team at Clinique dentaire du Versant.

Signature: _____ Date: _____