

Medical Questionnaire N°

First Name :
address :
E-mail address :

Name :

N° Tél :
N° CNS :
Profession :

This medical questionnaire is confidential and is intended for the exclusive use of your dentist in his professional practice. The information you were asked to provide at the reception desk, when setting up or updating your medical file, will be recorded on a computer, unless you have a justified objection. You can access the information concerning you through your health professional.

How did you hear about our firm? Doctena Other:

Reason for consultation : Check-up / Cleaning Orthodontic treatment Pain Teeth, sensitive gums
 Other :

Date of last dental examination or treatment:

Have you ever had a panoramic x-ray performed ? No Yes (date) :

DO YOU HAVE OR HAVE YOU HAD ANY HEALTH PROBLEMS?

- | | |
|---|--|
| <input type="checkbox"/> Allergies (latex, penicillin or other)
.....
<input type="checkbox"/> Cardiovascular disorders
<input type="checkbox"/> Kidney disorders
<input type="checkbox"/> Digestive disorders
<input type="checkbox"/> Liver disorders (hepatitis A, B or C)
<input type="checkbox"/> Nervous disorders
<input type="checkbox"/> Depression
<input type="checkbox"/> Eye disorders
<input type="checkbox"/> Broncho-pulmonary disorders | <input type="checkbox"/> Skin disorders
<input type="checkbox"/> Hormonal disorders
<input type="checkbox"/> Diabetes type I / II
<input type="checkbox"/> Blood disorders (HIV)
<input type="checkbox"/> Bone or joint problems
<input type="checkbox"/> ENT problems
<input type="checkbox"/> Cancer
<input type="checkbox"/> Other (specify)
.....
..... |
|---|--|

ARE YOU CURRENTLY TAKING ANY MEDICATION? (IF YES, WHICH ONES): NO YES

HAVE YOU EVER HAD PROLONGED BLEEDING AFTER A CUT? NO YES

HAVE YOU ALREADY HAD SURGERY? (IF YES, WHICH ONES): NO YES

ARE YOU WAITING FOR YOUR DENTIST TO PROVIDE SOLUTIONS TO IMPROVE THE AESTHETICS OF YOUR SMILE? NO YES
Tooth alignment / Whitening ...

ADDITIONAL INFORMATION

<input type="checkbox"/> Are you pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes	CAISSE / MUTUAL : <input type="checkbox"/> CNS <input type="checkbox"/> CMCM (-) <input type="checkbox"/> CMFEP <input type="checkbox"/> CMCM (+) <input type="checkbox"/> CMFEC <input type="checkbox"/> DKV <input type="checkbox"/> BEI / CEE <input type="checkbox"/> Foyer <input type="checkbox"/> Privée <input type="checkbox"/> Other :
<input type="checkbox"/> Do you smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> How many cigarettes/day? 	
<input type="checkbox"/> Have you ever had braces? <input type="checkbox"/> No <input type="checkbox"/> Yes	

In accordance with the RGPD, you have the rights of access, rectification and erasure of your personal data, as well as the right to restrict processing, the right to object to processing, or the right to portability of your personal data which you can exercise by notifying us.

Note: Some procedures have a supplement not reimbursed by the CNS (code CP8).

I attest to the accuracy of this information and agree to report any changes in my health status. I will inform my practitioner at the next appointment.

le
Signature