Medical Questionnaire N° ……….

First Name : ………………………………………. Name : …………………………………………… N° Tél : …………………………………….

E-mail address : …………………………………………………@……………………………………… 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?

☐ **Allergies (latex, penicillin or other)**
...
☐ Cardiovascular disorders
☐ Kidney disorders
☐ Digestive disorders
☐ **Liver disorders (hepatitis A, B or C)**
☐ Nervous disorders
☐ Depression
☐ Eye disorders
☐ Broncho-pulmonary disorders
☐ Skin disorders

☐ Hormonal disorders
☐ **Diabetes type I / II**
☐ **Blood disorders (HIV)**
☐ Bone or joint problems
☐ ENT problems
☐ Cancer
☐ 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

☐ Are you pregnant?	☐ No	☐ Yes
☐ Do you smoke?	☐ No	☐ Yes
☐ How many cigarettes/day?	…………………………	
☐ Have you ever had braces?	☐ No	☐ Yes

CAISSE / MUTUAL :

☐ CNS	☐ CMCM (-)
☐ CMFEP	☐ CMCM (+)
☐ CMFEC	☐ DKV
☐ BEI / CEE	☐ Foyer
☐ Privée	☐ Other :……………………

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

Dr Renaud GALLIZZI & Dr Joffrey STREIFF