Name / LAST NAME :

Matricule :
health insurance fund :

Address :

Profession / Employer :

Zip code/Town :

Telephone :

GSM :

Office Phone :

Name, address and telephone of your doctor :

Medical specialist (if applicable) :

Did someone reccomend this dental office? Reason for your visit?

Are you currently taking **medication**? YES NO
If yes, Which? (Please provide us with a copy of the prescription)

Please check yes or no	YES	NO	**Space reserved for the Doctor**
Are you allergic to any drugs, anesthetics or any other substances?			
Have you ever had surgery?			
Are you a smoker?			
Do you have any heath issues :			
High blood pressure?			
Diabetes or high cholesterol?			
Liver or kidney problems?			
Hepatitis, HIV or other disease?			
Loss of consciousness?			
Asthma or epilepsy?			
Problem with blood clotting?			
Do you take aspirin regularly?			
Osteoporosis or other bone problem ?			
Have you had radiation treatment?			
Are you pregnant or breastfeeding?			
Notes or additional comments about your health :			

I the undersigned, **Mr/Mrs/Ms** .....
certify that I have disclosed to Doctor HOA all the medical information relevant to and regarding my current health status and agree to report any changes in my health or my treatments to Doctor HOA.
Signed the ..... in ..... **Signature**