THINC® VIRTUAL

Name: Date of Birth:

How would you like to be called? Martial Status:

Home Address: Postal Code:

Suburb: City: Province:

Occupation: Employer/Company:

ID: E-mail:

Home Number: Mobile: Work Number:

(Guardian (if minor) or Spouse: Number:

Social Media: Instagram Facebook:

Who can we thank for your referral:

STATE OF GENERAL HEALTH

Please answer the following questions:
The purpose of this questionnaire is to provide significant clinical information related to your health, this will provide individualized planning and ensure greater safety during treatment procedures. Our responses are confidential. Comments can be made int he blanks. Thank you.

1) What is the main reason that lead you to seek treatment:

2) Currently under medical treatment? Details?

3) Are you taking any medication? Details?

4) Has suffered or is suffering from:

☐ Depression	☐ Fainting	☐ Rheumatism	☐ Leakage	☐ Respiratory
☐ Diabetes	☐ Migraine	☐ Convulsion	☐ Glaucoma	☐ Renal
☐ Gastritis	☐ Hypertension	☐ Hepatitis	☐ AIDS	☐ Thyroid
☐ Asthma	☐ Ulcer	☐ Cancer	☐ Heart	

5) Do you have any problem healing? ( )Y ( )N

6) Have you been subjected to blood transfusion? ( )Y ( )N

7) Have you ever had radiation or chemotherapy treatments? ( )Y ( )N

8) Have you had any adverse reactions to medicine? ( )Y ( )N

9) Do you have or have you had any allergies? ( )Y ( )N

10) Do you have or have you had an eating disorder? ( )Y ( )N

11) Do you smoke? How many cigarettes a day? ( )Y ( )N

12) Do you usually drink alcohol? ( )Y ( )N

13) For women: Are you pregnant? ( )Y ( )N

14) Do you have any breathing difficulties or airway obstructions? ( )Y ( )N

15) Do you have any type of sleep disorder or apnea? ( )Y ( )N

16) Do you use any sleeping pills? ( )Y ( )N

17) Do you have or have you had digestive problems?(Eg.: Intolerance, reflux, regurgitation, frequent vomiting) ( )Y ( )N

18) Are you dissatisfied with the appearance of your smile? ( )Y ( )N

19) Do you have restorations that you don't like the look of? ( )Y ( )N

20) Do you have restorations that you don't like the look of? ( )Y ( )N

21) When do you have your last dental treatment? ( )Y ( )N

22) Do you have any fears about the treatment? ( )Y ( )N

23) Did you have any complications in previous treatments? ( )Y ( )N

24) Do you have any teeth in pain or tenderness? ( )Y ( )N

25) Do you feel any cavities in your teeth? ( )Y ( )N

26) Have you had cavities in the past 3 years? ( )Y ( )N

27) When you floss does it stick to a tooth? ( )Y ( )N

28) Do you normally feel dry mouth? ( )Y ( )N

29) Did you have oral hygiene instructions? ( )Y ( )N

30) Did you have a problem with your breath? ( )Y ( )N

31) Have you ever had gum treatment? ( )Y ( )N

32) Does your gum bleed easily? ( )Y ( )N

33) Do you have gingival recession? ( )Y ( )N

34) Do you have difficulty, pain or both when opening your mouth when yawning? ( )Y ( )N

35) Does your jaw "stick", lock or move? ( )Y ( )N

36) Do you notice a noise in your jaw joints? ( )Y ( )N

37) Do your jaws get stiff, tight or tired regularly? ( )Y ( )N

38) Do you have pain in or around your ears, temples and cheeks? ( )Y ( )N

39) Do you have headache, neck or teeth pain often? ( )Y ( )N

40) Have you had any recent head, neck or jaw trauma? ( )Y ( )N

41) Did you notice any recent changes in your bite? ( )Y ( )N

42) Have you had recent treatment for any temporomandibular joint problem? ( )Y ( )N

43) Have you ever used a bite plate? ( )Y ( )N

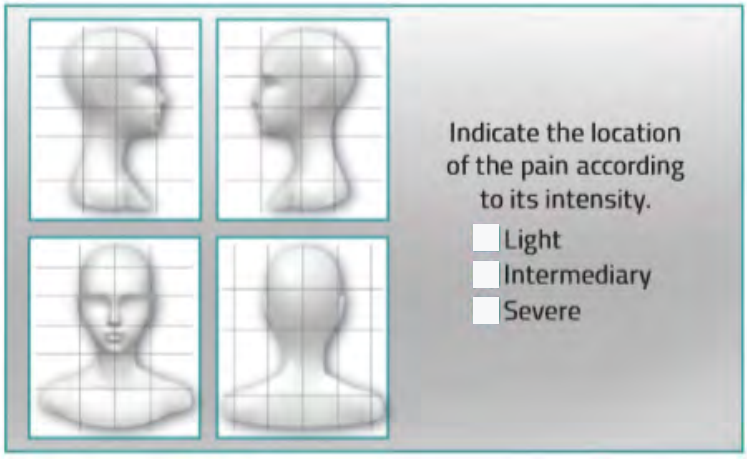
44) Have you noticed wear or splinters on your teeth recently? ( )Y ( )N

45) Do you feel pain in your face? Frequency: ( ) I don't feel pain ( ) Rare ( ) Daily ( ) Weekly ( ) Monthly

46) Type of pain: ( ) Pulsating, throbbing ( ) Continuous ( ) Shock ( ) Burning ( ) Other

47) Do you have generalized pain? (chronic}: ( ) Never ( ) From time to time ( ) Always ( ) Very often

48) Do you have or have problems with your cervical or lumbar spine? ( ) Yes ( ) No



49) Do you have a history of neural disorders (attention deficit hyperactivity disorder, post-traumatic syndrome, panic syndrome, anorexia, bulimia, dyslexia or others}? ( )Y ( )N

50) What is your degree of tension and/or anxiety? ( )Y ( )N

51) Do you feel or have emotional changes (crying crisis}, lack of self-confidence, feeling of failure, loss of libido, loss of appetite or compulsion for food, lack of motivation to have fun? ( )Y ( )N

52) Do you make chronic use of pain relief medications or for other reasons? ( )Y ( )N

53) Is there any important information about your health that has not been considered? ( )Y ( )N

COVID-19 PANDEMIC – DISCLOSURE AND CONSENT FORM

I _____ knowingly and willingly consent or for myself or for a minor

_____under my care to have treatment during the COVID-19 pandemic.

I understand that:

- People can catch COVID-19 from others who have the virus
- The disease can spread from person to person through small droplets from the nose or mouth which are spread when a person with COVID-19 coughs or exhales
- These droplets land on objects and surfaces around the person
- Other people then catch COVID-19 by touching these objects or surfaces, then touching their eyes, nose or mouth
- People can also catch COVID-19 if they breathe in droplets from a person with COVID-19 who coughs out or exhales droplets
- This is why it is important to stay more than 2 meter away, especially from a person who is sick
- The COVID-19 virus has a varied incubation period during which carriers of the virus might not show symptoms yet still be highly contagious

I confirm that in the past 14 days I have not had the following symptoms of COVID-19 listed below (and that I will inform the practice immediately should I develop these symptoms).

- Fever (temperature > 37,5 degrees)
- Shortness of breath
- Sore throat
- Cough
- Tiredness
- Diarrhoea or other digestive upset
- Loss of sense of taste or smell
- Any new skin condition on toes and hands

_____ (Initial)

Regarding exposure to the virus:

-
- I confirm that I have not been in contact (work or social) or living with any person suspected or confirmed of COVID-19 infection?
- I have not tested positive for COVID-19
- If I have recovered from COVID-19, I will wait 4 weeks before aesthetic treatments and show my doctor the negative test result. _____ (Initial)

Signature _____ Date_____

Name of Patient/Parent/Guardian _____