MARKHAM HERITAGE HEALTH CLINIC – DENTISTRY ADULT

Name____ Sex: M / F Marital Status:__________________
Address: ______________________________________ City: ______________ Postal Code______________
Home Tel# _________________________ Bus# _________________________Cell# ____________________
E-mail address: __________________________________ May we call you at work? __________________
Date of Birth________________ Employer _________________________ Occupation _________________
In case of emergency, whom may we contact? ______________________ Phone: ___________________
How did you hear about our office? /Who can we thank for referral: ______________________________

Medical Questionnaire **Circle One**

Are you presently under the care of a physician? When was last physical Yes No
If so, specify____
Are you taking any medicines (antibiotics, birth control, painkillers etc) Yes No
If yes, please list all medications that you take, the doses and what they are for

__________________________________ ____________________________________
__________________________________ ____________________________________
__________________________________ ____________________________________
__________________________________ ____________________________________

Have you ever been hospitalized? If so, when and how long? ______________________ Yes No
Do you have drug allergies? If so, specify ____ Yes No
Have you ever had an unusual reaction to any drugs or medications? Yes No
If so, specify ____
Do you have any other allergies (food, latex, metal, hay fever)? Yes No
If so, specify ____
Do you have a bleeding problem or disorder? If so, specify __________________________ Yes No
Do you smoke? Yes No How many per day? ______________
Do you drink alcohol Yes No How many per day? ______________
Have you had radiation treatment or chemotherapy? If so, explain __________________ Yes No
If so, explain ___________________________

Women: Are you pregnant? Yes No what month? ______ Are you nursing? Yes No

Do you have or have you ever had any of the following? (Please circle all that apply)

Anemia	Cancer	Heart Trouble	Rheumatic fever
Arthritis	Diabetes	Hepatitis A,B,C/ Jaundice	Stomach/ intestinal trouble
Artificial Heart Valve	Eating Disorders	Herpes type I/ type II	Strokes
Artificial joint/implants	Epilepsy/ seizures	High/ Low blood pressure	Thyroid disease
Asthma	Head/ Neck injuries	HIV virus/ AIDS	Tuberculosis
Blood disorders	Heart Murmur	Kidney disease	Other:

Do you wish to speak to the dentist privately about any matter? Yes No

Dental Information

Is there any dental problem you would like treated immediately? Yes No
If so, specify____
Have you been seeing a dentist regularly? Yes No
Date of last visit: _______Last x-rays:_____ last professional cleaning _____
Have you ever been to a dental specialist? Yes No
If so, for what were you treated? ___________________________________

Are there any growths or sore spots in you mouth? Yes No

Do your gums bleed when brushing, eating, or do you have pain in your gums? Yes No

Does food catch between your teeth? Yes No
Are any of your teeth sensitive to heat, cold, sweets or pressure? Yes No
Do you use dental floss, proxabrush, stimudents? Yes No
How often do you brush your teeth? _____________ When?_______________

Do you feel that you have bad breath? Yes No

Do you clench or grind your teeth while awake or asleep? Yes No
Do you have frequent headaches? Yes No
Do you snore? Yes No
Have you ever been diagnosed with Sleep Apnea? Yes No
If yes, do you use a CPAP machine or an Oral Appliance ________________
Do you drink coffee, tea, cola regularly? Yes No How much a day? _________
Do you have any emotional concerns about dental treatment? Yes No
Have you ever had an upsetting experience in a dental office, any complications? Yes No
Do you have any questions or concerns about dental treatment? Yes No
If yes, please specify ____
Are you unhappy with the appearance of your teeth? Yes No
What would you like to see changed? _______________________________
What are your long term goals for your teeth, mouth, and smile? _________
What qualities do you look for in a dentist?______________________________
What are your expectations of our office?_______________________________

Insurance Information
Name of Insured: _______________________________Birth Date of Insured: ______________
Insurance Company: ____________________ Group # ______________ID# _________________
Do you have any additional insurance? Yes No If yes, complete the following:
Name of Insured: _______________________________Birth Date of Insured: ______________
Insurance Company: ____________________ Group # ______________ID# _________________

Who is responsible for this account? ____

Financial Policy:

I assume responsibility of all fees associated with treatment and fully understand that payment is expected on the date of treatment.

Consent for Treatment: This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary if advisable, including the use of local anesthetic as indicated and accept the Financial Policy above.

Signature:____ Date: __________________

Reviewed by treating dentist: _________________________ Date: __________________