Markic Dental

Patient Information:

Last name _____ First name _____

Address _____City_____Postal Code_____

Birthdate: (d/m/y) ____/____/_____ Gender: __ M __ F Occupation:_____

Phone HOME: ( ) _____ BUSINESS: ( ) _____ CELL: ( ) _____

Email: _____ Do you wish to receive reminders by ____email ? ____ text?

Referred by: _____

In case of Emergency, notify: name, phone, relationship:_____

Who is legally responsible for payment of this account?
___Self ____ Other person: name, relationship, phone #_____

Dental Information:

Purpose of today's visit: ___check-up (exam) ___cleaning ___specific problem ___toothache ___other

Previous Dentist Name and location: _____
Approximate date of last visit:_____ How often do you go to the dentist? _____

Do you have, or have you ever had, any of the following? Please check off all that apply:

- ☐ teeth sensitive to cold
- ☐ teeth sensitive to sweet
- ☐ gums bleed when brush / floss
- ☐ bad breath
- ☐ dry mouth
- ☐ clench or grind teeth
- ☐ jaw clicks, pops or locks
- ☐ frequent headaches
- ☐ canker sores / cold sores
- ☐ food caught between teeth
- ☐ loose teeth
- ☐ chipped teeth
- ☐ had wisdom teeth removed
- ☐ had orthodontics (braces)
- ☐ had periodontal (gum) surgery

How nervous are you about dental treatment? Indicate by circling on the scale below:

NOT AT ALL – 1 – 2 – 3 – 4 – 5 – *VERY ANXIOUS*

If nervous, are you interested in additional techniques, along with "freezing" to help you? ___Y ___N ___ maybe

Have you had any problems or complications with previous dental treatment? ___Y ___N ___ maybe

Do you have interest in wanting to change the appearance of your teeth or smile? ___Y ___N ___ maybe

Medical Information:

Physician's name, address, phone: _____

Do you have or have you ever had any of the following? Please check off all that apply:

- ☐ High Blood pressure
- ☐ Low Blood pressure
- ☐ Cholesterol high
- ☐ Angina
- ☐ Heart attack
- ☐ Stroke
- ☐ Heart surgery
- ☐ Artificial heart valve
- ☐ Heart infection (endocarditis)
- ☐ Heart transplant
- ☐ Congenital heart defect (birth)
- ☐ Heart murmur
- ☐ Mitral valve problems
- ☐ Pacemaker
- ☐ Other heart problem

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Do you have, or have you ever had, any of the following? Please check off all that apply:

☐ Artificial joint (knee, hip, other)	☐ AIDS / HIV infection	☐ Steroid therapy	☐ Epilepsy or seizures
☐ Arthritis	☐ Hepatitis	☐ Diabetes	☐ Mental health issue
☐ Osteoporosis	☐ Liver disease	☐ Kidney disease	☐ Skin condition
☐ Back / neck issue	☐ Bleeding disorder	☐ Thyroid condition	☐ Vertigo / balance
☐ Autoimmune issue	☐ Asthma	☐ Digestive problems	☐ Hearing problem
☐ Cancer	☐ Lung disease	☐ Stomach ulcers	☐ Sleep apnea
	☐ Tuberculosis	☐ GERD / acid reflux	☐ Prone to fainting

Are there any OTHER conditions or diseases that you have or have been treated for:
If YES, list _____

	yes	no	?
Are you taking ANY medications or non-prescription drugs of any kind? If YES, list:_____	☐	☐	☐
Do you have any environmental allergies? (eg. hayfever, foods, latex / rubber, metals, acrylic) If YES, list:_____	☐	☐	☐
Have you ever had an allergy or adverse reaction to any medicine or injections? (eg. Penicillin, aspirin, local anaesthetics "dental freezing", codeine, sulpha) If YES, list:_____	☐	☐	☐
Have you ever been hospitalized for any illnesses or operations? Explain:_____	☐	☐	☐
Are there any disease or medical problems that run in your family? (eg. diabetes, cancer, heart disease)_____	☐	☐	☐
Do you or did you smoke tobacco (or vape)? If so, how much? _____	☐	☐	☐
Do you drink alcoholic beverages on a regular basis? If so, how much? _____	☐	☐	☐
Do you use recreational drugs? (eg. marijuana, cocaine) If so, how much? _____	☐	☐	☐
Do you identify as a patient with a disability? If so, explain:_____	☐	☐	☐
For women only: are you pregnant? If yes, due date:_____	☐	☐	☐

I acknowledge that the information given above is true to the best of my knowledge. Should there be any change to my present health status in the future, I will advise the attending dentist / hygienist.

Where my physician may need to be contacted, I consent to my physician providing any information with regards to details in my medical history which may help ensure a safe dental treatment. I understand that treatment may be delayed until all medical information required is received.

This is to certify that I, the undersigned, consent to the performing of dental procedures agreed to be necessary or advisable including the use of local anaesthetic and / or relative analgesia as indicated and I will assume responsibility for fees associated with those procedures. I also consent to sharing my information and discussion with dental specialists as required for my overall dental health and treatment plan.

I understand the appointment policy where my appointment time will be reserved time specifically for me and if unable to keep my appointment, the office requires 48 hours notice otherwise it may be necessary to charge for time lost.

Patient signature: _____Date:_____

Reviewed by Dentist:_____