Markham Orthodontic Specialty

Welcome to our Office **Today Date:**

Patient Name: ____
Last First MI

DOB: (mm/dd/yyyy) ________/________/________ **Sex:** Male / Female **Marital Status:** S M D W

Address: ____
Street Apartment #

____
City Province Postal Code

Home: ______________________ **Work:** ______________________ Ext:________

Mobile: ______________________ **E-mail:** ______________________

Name of Employer or School: ______________________ **Grade:** ________

Emergency Contact:

Name: ______________________ Telephone # ______________ Relationship: ______________

Referral Information: Whom may we thank for referring you to our practice?

☐ Dentist: ______________ ☐ Doctor: ______________ ☐ Family: ______________ ☐ Friend: ______________

☐ Sign: ______________ ☐ Website: ______________________ ☐ Other: ______________

Financial Information

Person Responsible for Bill	Primary Insurance (optional)	Secondary Insurance (optional)
Name	Name of Subscriber	Name of Subscriber
Occupation	Date of Birth (mm/dd/yyyy) / /	Date of Birth (mm/dd/yyyy) / /
Employer	Employer	Employer
Business .#	Insurance company	Insurance company
Dental Insurance Yes No	Policy or plan #	Policy or plan#
Relationship to Patient:	Cert.or ID#	Cert. or ID #

Financial Policies Please Initial

________ I authorize release, to my insuring company plan administrator and CDA, the information contained in claims submission.

________Your insurance benefits are between you, your employer and your insurance company. Any benefit difference (deductible, fee guide, ineligible service or co-payment) is your responsibility. All estimates for care are approximate.

Dental Information

Name of Current Dentist: ______________________ Phone: ______________________

What concerns you most about your smile? ______________________

Do you require antibiotics before dental treatment? ☐ No ☐ Yes

Do you have any pain or tiredness in the jaw or face during chewing? ☐ No ☐ Yes

Are you aware of your jaw clicking or popping? ☐ No ☐ Yes

Are you aware of clenching or grinding your teeth during the day or at sleep? ☐ No ☐ Yes

Has a thumb or finger sucking habit exited past the age of five? ☐ No ☐ Yes

Date of last dental checkup & cleaning: ______________________

Do you visit your dentist or dental hygienist in a regular basis? ☐ No ☐ Yes, how often? ______________________

Do you: ☐ Brush, how often? __________ ☐ Floss, how often? __________

☐ Other dental aids? __________, how often? __________

Health Information

Have you ever had?

☐ AIDS or HIV
☐ Abnormal Bleeding / Hemophilia
☐ Anemia
☐ High / Low Blood Pressure
☐ Diabetes
☐ Heart Problems
☐ Heart Murmur
☐ Enlarged Tonsils
☐ Asthma
☐ Congenital Heart Defect
☐ Rheumatic Fever
☐ Tumor or Cancer
☐ Radiation / Chemotherapy
☐ Hepatitis / Liver Problem
☐ Kidney Problem
☐ Herpes
☐ Mouth Breathing Habit
☐ Cold Sores / Fever Blisters
☐ Venereal Disease (Syphilis / Gonorrhea
☐ Epilepsy
☐ Tuberculosis
☐ Sinus Problems
☐ Bone Disorders
☐ Nervous Disorders
☐ Trauma to Teeth Habits

Are you allergic to?

☐ Penicillin ☐ Sulfa ☐ Mycins or other Antibiotics ☐ Aspirin, Codeine or Morphine

☐ Any other drug ______________________ ☐ Any foods __________

☐ Latex or Adhesive tape ☐ Tetanus Antitoxin or Serums

Name of Physician: ______________________ Phone: ______________________

Are you now under the care of a physician? ☐ No ☐ Yes, please explain: ______________________

Please list your medications: ______________________

Have been to a hospital or needed emergency care during the past 2 years? ☐ No ☐ Yes, please explain: __________

WOMEN: Are you pregnant?________If yes, what month?______Are you nursing?_____Are you taking birth control?__________

Do you have any health problems that need further clarification? ______________________

Please Initial

________ To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there is any change in health, I will inform the doctors at the next appointment without fail.

I have read the above conditions of treatment and payment and agree to their content.

For office use
Comments:
Status:

X

Signature of patient, parent, guardian or guarantor of payments — Date — Relationship to Patient