MARTINDALE DENTAL

PATIENT CONTACT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ (DD/MM/YY) ☐ Male ☐ Female

Address: _____ Apt/Unit#: _____

City: _____ Province: _____ Postal Code: _____

Home Telephone Number: _____ Email: _____

May we contact you at your workplace? ☐ Yes ☐ No Work Number: _____ Ext. _____

May we contact you on your cellular phone? ☐ Yes ☐ No Cell Number: _____

May we contact you by email? ☐ Yes ☐ No Email Address: _____

Employer: _____ Position: _____

Marital Status: ☐ Single ☐ Married/Common Law ☐ Other

Best way to contact you: ☐ Home# ☐ Work# ☐ Cell# ☐ Email

Best time to contact you: ☐ Morning ☐ Afternoon ☐ Evening

In case of an emergency - please notify: _____ Telephone Number: _____

REFERRAL INFORMATION

How did you hear about us? (Check all that apply)

☐ Internet Web site/search engine source: _____

☐ Flyer Flyer description: _____

☐ Newspaper Newspaper name(s): _____

☐ Phone Book Publisher: ☐ Yellow Pages ☐ CanPages ☐ PhoneGuide ☐ GoldBook

☐ Radio Station(s): _____

☐ Event Event name: _____

☐ Word of Mouth Name of person: _____

☐ Other Please specify: _____

☐ Mobile Sign

☐ New Resident Welcome

☐ Walked By

☐ Ad Perks/Work Perks

INSURANCE INFORMATION

Primary Insurance Company Information

Name of Insurance Policy Holder: _____ Date of Birth: _____ (DD/MM/YY)

Insurance Policy Holder: ☐ Self ☐ Parent/Guardian ☐ Other _____

Policy Holder Contact Phone Number: _____ (if different from above)

Group Policy/Plan Number: _____ I.D./Certificate Number: _____

Insurance Company Name: _____

Secondary Insurance Company Information

Name of Insurance Policy Holder: _____ Date of Birth: _____ (DD/MM/YY)

Insurance Policy Holder: ☐ Self ☐ Parent/Guardian ☐ Other _____

Policy Holder Contact Phone Number: _____ (if different from above)

Group Policy/Plan Number: _____ I.D./Certificate Number: _____

Insurance Company Name: _____

DENTAL HISTORY

Please check any of the following problems that may apply to you.

- ☐ Sensitivity (hot, cold and/or sweet)
- ☐ Tooth pain or discomfort while chewing
- ☐ Headaches, earaches or neck pain
- ☐ Jaw joint pain (clicking/cracking)
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

☐ Dentures ☐ Braces ☐ Partial dentures ☐ Periodontal (gum) treatments

Please share the following dates:

Your last dental cleaning: _____ /_____

Your last oral cancer screening: _____ /_____

If you could whiten your teeth for a cost anyone could afford, would you do it? ☐ Yes ☐ No

Do you smoke or use chewing tobacco? ☐ Yes ☐ No

If yes, how often? _____ For how long? _____

If you could change your smile, you would...

- ☐ Make your teeth brighter
- ☐ Make your teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings with natural, tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

On a scale of 1 to 10, with 10 being the highest rating

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? _____

_____

What, if anything, in the past has kept you from having dental treatment? _____

_____

What is the most important thing to you about your future smile and dental health? _____

_____

What is the most important thing to you about your visit today? _____

_____