marchdental
"Where Smiles Come Alive"

WELCOME

Patient Information:

Last Name: _____ First Name: _____

Date of Birth: MM_____ /DD_____ /YYYY_____ Occupation: _____

Tel.: Home (_____) _____ - _____ Work #: (_____) _____ - _____ Ext. _____

Cell: (_____) _____ - _____

Email Address: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Person Responsible for this account: Full Name: _____

Relationship to the patient: _____

Emergency contact: _____ Relationship:_____

Tel.: Home (_____) _____ - _____ Work #: (_____) _____ - _____ Ext. _____

Cell: (_____) _____ - _____

Insurance Information:

Primary:

Policy Holder's Full Name: _____D.O.B: MM_____ /DD_____ /YYYY_____

Insurance Company: _____

Group/Policy #: _____ I.D./Certificate #: _____

Secondary:

Policy Holder's Full Name: _____D.O.B: MM_____ /DD_____ /YYYY_____

Insurance Company: _____

Group/Policy #: _____ I.D./Certificate #: _____

Dental Information:

		YES	NO
1	Chief complaint: _____		
2	Last Dental Exam: _____ Last Dental Hygiene Visit: _____		
3	Are you experiencing any dental pain		
4	Have you been seeing a dentist regularly		
5	Are there any growths or sore spots in your mouth		
6	Have you noticed any loose teeth or teeth that have shifted		
7	Does food get caught between your teeth		
8	Are any of your teeth sensitive to heat, cold, sweets or pressure		
9	Have you ever been advised to take antibiotics before a dental appointment		
10	Do you use dental floss, proxabrush or stimudents? How often: ☐ Daily ☐ Weekly ☐ Monthly		
11	Do you brush your tongue or use a tongue scraper? How often: ☐ Daily ☐ Weekly ☐ Monthly		
12	How often do you brush your teeth: No. of times:_____ per ☐ Day ☐ Week ☐ Month		
13	Do you experience bad odour or a bad taste in your mouth		
14	Do you experience bleeding when brushing or flossing		
15	Diet: SUGAR ☐ low ☐ med ☐ high ACID ☐ low ☐ med ☐ high		
	DO YOU HAVE OR HAVE EVER HAD		
16	Periodontal (gum) treatment(s)/surgery		
17	Orthodontic treatment (to straighten or align your teeth)		
18	Oral Surgery (surgery in or about the mouth, jaw joint, other:_____)		
19	Root canal treatment		
20	Tooth extraction(s)		
21	Crowns or bridges		
22	Complete or Partial Dentures		

		YES	NO
23	Dental implants		
24	Restorative fillings		
25	Night guard or any other appliance		
26	Your bite adjusted or your teeth ground		
27	Pain in your jaw, around your ear or side of your face		
28	Popping/clicking in your jaw joints		
29	Difficulty opening or closing		
30	Pain/difficulty chewing		
	DO YOU HAVE ANY OF THE FOLLOWING HABITS		
31	Clench or grind your teeth while sleeping or awake		
32	Biting your cheeks or lips regularly		
33	Breathing through your mouth while awake or asleep		
34	Hold or bite foreign objects with your teeth (pencils, nails, pipes, pins, fingernails)		
35	Do you have any emotional concerns about having dental treatment		
36	Are you happy with the appearance of your teeth **If no**, what would you like to see changed		
37	Is there anything preventing you from getting optimal dental treatment for your oral health (i.e. fear, time, cost, lack of understanding of treatment required)		
38	Have you ever had an upsetting/unpleasant experience in a dental office or any complications During or following dental treatment.		
39	Do you have any questions or concerns or special requests for treatment		
40	What are your dental goals and/or expectations		

Insurance and Payment Policies/Electronic Benefit Assignment Authorization: By signing, I authorize release to my insuring company(s) plan administrator(s) the information contained in claims submitted electronically. I am aware that March Dental will directly submit my insurance claims on my behalf however I acknowledge that I am fully responsible for providing payment in full to March Dental at the time of service for all fees incurred.

_____ _____

Name Signature

_____

Date