coast
DENTAL SPECIALISTS

DR. NAYEEM ESMAIL, DMD, FRCD(C)
Certified Specialist in Oral & Maxillofacial Surgery

PLEASE EMAIL: SunshinecoastOMS@gmail.com

PLEASE CALL: 1 (888) 801-6911

ONLINE PATIENT REGISTRATION

1. PATIENT INFORMATION

Patient: _____ ☐ M ☐ F DOB (M-D-YY): _____

Care Card Number: _____

Address: _____

City: _____ Postal Code: _____

Email: _____

Home Tel: _____ Cell: _____ Bus: _____

Referring Dentist: _____ Tel: _____

Family Physician: _____ Tel: _____

2. IF PATIENT IS A MINOR

Father's Name: _____ Father's Tel: _____

Mother's Name: _____ Mother's Tel: _____

Guardian's Name: _____ Guardian's Tel: _____

3. INSURANCE INFORMATION

(If you do not have this information, please contact your employer or dental office to provide you with it.)

PRIMARY DENTAL PLAN

Policy Handler's First Name: _____ Policy Handler's Last Name: _____

Employer: _____ Date of Birth: _____

Insurance Co. Name: _____ Group Policy #: _____

Certificate/ID #: _____ Plan %: _____ Dependant #: _____

SECONDARY DENTAL PLAN

Policy Handler's First Name: _____ Policy Handler's Last Name: _____

Employer: _____ Date of Birth: _____

Insurance Co. Name: _____ Group Policy #: _____

Certificate/ID #: _____ Plan %: _____ Dependant #: _____

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ONLINE MEDICAL HISTORY

PLEASE ANSWER THE QUESTIONS BELOW

1. Is your physician treating you for a medical problem? ☐ Yes ☐ No

   If yes, what condition(s) is (are) being treated? _____

2. Have you had an operation or hospitalization ☐ Yes ☐ No If yes, please list type and date below:

   _____

   Were there problems with the general anesthetic? ☐ Yes ☐ No

   If yes, please explain: _____

3. Do you have, or have you had, any of the following?

☐ Alcohol/Drug Use	☐ Cancer	☐ Immune Deficiency	☐ Rheumatic Fever
☐ Arthritis	☐ Diabetes	☐ Kidney Problems	☐ Seizures
☐ Asthma	☐ Glaucoma	☐ Liver Disease	☐ Stroke/TIA
☐ Blood Disorders	☐ Heart Disorder	☐ Lung Disease	☐ Thyroid Disorder
☐ Bronchitis	☐ Hepatitis/Jaundice	☐ Mental Disorders	☐ Ulcers

4. Do you have any other medical conditions not listed you feel we should know about? ☐ Yes ☐ No

   If yes, please explain: _____

   Do you have any history of family disease? ☐ Yes ☐ No

   If yes, please explain: _____

5. Do you smoke? ☐ Yes ☐ No How many a day? _____ How many years? _____ If you quit, what year? _____

   Do you drink alcohol? ☐ Yes ☐ No How often? _____

   Do you use any drugs? ☐ Yes ☐ No If yes, please list: _____

6. Are you pregnant? ☐ Yes ☐ No ☐ N/A How many months? _____ Are you breastfeeding? ☐ Yes ☐ No

7. Have you ever had an allergic reaction to medication(s), including latex? ☐ Yes ☐ No

   If yes, which medication (s) and what reaction? _____

8. Are you presently taking any medication(s)? ☐ Yes ☐ No

   (Please write down the name of medication(s) or provide a list.)

   _____

CONSENT

I, the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted information. I also consent to my physician being contacted if necessary to obtain information that is required for my care.

By checking the box below and typing my name below, I am electronically signing this consent form.

PATIENT, PARENT, OR LEGAL GUARDIAN SIGNATURE

☐ I, _____ , state that all the answers given in this consent form are truthful.

DATE _____ **SIGNATURE** _____