

Dr. Marnie



Name: _____ Birth Date: _____ Male ___ Female ___
Address: _____ City: _____ Province: _____
Postal Code: _____ Email: _____
Phone: (Home) _____ (Work) _____ (Cell) _____
Do you want us to contact you by e-mail _____

How did you hear about Dr. Marnie? _____

I am interested in: Circle all that apply:

Botox Cosmetic	Invisalign - invisible braces
Zoom Tooth Whitening	Cosmetic smile makeover
Sleep Dentistry for nervous individuals	Periodontal Disease or Laser Treatment
Bad Breath or Halitosis	TMJ or TMD or Headaches
Grinding, Clenching or Bruxism	Removing mercury fillings
Dental Implants	

Medical History: Circle any condition for which you have ever been treated

Diabetes	Rheumatic Fever	Epilepsy
Hypertension	Kidney disease	Cardiovascular Disease
Respiratory Disease	Hepatitis or HIV	Prolonged Bleeding
Cold sores	Canker sores	Local anesthetic sensitivity

Family Physician _____ Do you have any drug allergies _____

Have you had any serious past illnesses or surgeries: _____

Do you take any current medications including aspirin, birth control, herbal medication: _____

Do you smoke? _____ How many per day? _____

Are you currently being treated for any conditions not listed? _____

Are you currently pregnant or breast feeding? _____

We want to be here for you. If there were one thing we could do to help meet your needs what would that be? _____
