Welcome To

Markham NS Dental

Care, Comfort, Convenience, Confidence.....

PID : _____ SCAN : ☐

Personal Information (Confidential)

To help us meet your dental health care needs,
Please fill out this form completely

☐Mr. ☐Mrs. ☐Miss. ☐Ms. ☐Dr. ☐ Single ☐ Married ☐ Other _____ ☐Male ☐Female

Name: _____
(Last Name) (First Name) (Initial)

Preferred Name : _____ Date Of Birth: ___/___/___
DD/MM/YYYY

Address: _____
(Street) (Apt #)

_____
(City) (Province) (Postal Code)

Phone: **H**ome: ( ) - **W**ork: ( ) - x

Cell: ( ) - **O**ther: ( ) -

Email: _____ Are you available on short notice for appointments? ☐ Yes ☐ No

Best way to contact : ☐ **H**ome ☐ **C**ell ☐ **W**ork ☐ **O**ther ☐ **E**mail ☐ **T**ext

Best Time to call : ☐ **A**ny time ☐ **M**orning ☐ **A**fter Noon ☐ **E**vening

Preferred day of visit : ☐ **A**ny day ☐ **M**on ☐ **T**ue ☐ **W**ed ☐ **T**hu ☐ **F**ri ☐ **S**at ☐ **S**un

Employer/School: _____ Occupation: _____

Family Physician: _____ Phone No: ( ) -

In Case of Emergency: _____ ( ) -
Notify Name Relationship Phone No:

Are You Familiar with Your Dental Plan details? ☐ Yes ☐ No _____

Responsible Party (If different from above)

Name: _____ DOB: _____
(Last Name) (First Name) (Initial) DD/MM/YYYY

Address: _____
(Street) (Apt.) (City) (Prov.) (Postal Code)

Phone: **H**ome: ( ) - **W**ork: ( ) - x

Primary Insurance

Subscriber _____ DOB _____
1st INSURANCE HOLDER NAME DD/MM/YYYY

Relation: ☐ Self ☐ Spouse ☐ Other _____

Insurance Co: _____ Phone No: ( ) -

Certificate / ID # _____ Policy / Plan / Group # _____ Division/Sect: _____

Secondary Insurance

Subscriber _____ DOB _____
2nd INSURANCE HOLDER NAME DD/MM/YYYY

Relation: ☐ Self ☐ Spouse ☐ Other _____

Insurance Co: _____ Phone No: ( ) -

Certificate / ID # _____ Policy / Plan / Group # _____ Division/Sect: _____

Referral Information (Whom we can thank for referring you to our office):

☐ Another Patient, ☐ Friend, ☐ Relative, ☐ Professional ☐ Staff Member _____
Referred by

How did you hear about us? ☐ google ☐ TV, ☐ Radio ☐ Flyer, ☐ Website, ☐ Newspaper, ☐ Walk-IN, ☐ Other: _____

MEDICAL HISTORY

All information is confidential

The following information is required by the dentist to assist in proper diagnosis and treatment

1. Have you ever had a serious illness, requiring hospitalization in the past five years or extensive medical care? ☐ Yes ☐ No
   Please Specify: _____
2. Are you presently under the care of physician? Explain: _____ ☐ Yes ☐ No
3. Do you use any prescription or non prescription drugs regularly? Specify: _____ ☐ Yes ☐ No
4. Do you have any allergic conditions: e.g. hay fever, skin rash, food allergies, metal, latex? ☐ Yes ☐ No
5. Do any allergic reactions result in headaches, shortness of breath, chest constrictions, nausea? ☐ Yes ☐ No
   Please Specify: _____
6. Have you ever experienced any unusual reaction to any of the following
   ☐ Local anesthesia (freezing) ☐ aspirin ☐ penicillin ☐ codeine ☐ sulpha drugs ☐ barbiturates (sleeping pills) ☐ any other medicine
   Please explain: _____
7. Have you been warned against taking any drug or medication? ☐ Yes ☐ No
8. Do you have any of the following? Please check any that apply: ☐ Yes ☐ No

☐ Heart Murmur or Mitral valve Prolapse	☐ Malignant Hyperthermia	☐ Joint Replacement	☐ Diabetes	☐ Stroke	☐ Liver Disease
☐ Stomach/Intestinal Problems/Ulcers	☐ Drug/Alcohol Dependency	☐ Kidney Problems	☐ Herpes	☐ Hepatitis A/B/C	☐ Emphysema
☐ Mental or Nervous disorder	☐ Arthritis or Rheumatism	☐ Cold Sores	☐ Jaundice	☐ Lung Disease	☐ Sinus Trouble
☐ High/low blood pressure	☐ Scarlet or Rheumatic Fever	☐ Tuberculosis	☐ AIDS/HIV	☐ Thyroid Disease	☐ Glaucoma
☐ Hyper/Hypo Glycemia	☐ Cortisone/Steroid Therapy	☐ Epilepsy or Seizures	☐ Heart Attack	☐ Cancer/Chemotherapy	☐ Fainted ever
☐ Organ Implants or Medical Implants	☐ Experience shortness of Breath or Chest Pain when walking or climbing stairs			☐ Bruise easily or bleed abnormally	

9. Have you had any injury, surgery or x-ray therapy to your face or jaws? ☐ Yes ☐ No
10. Do you have any disease, condition or problem that you think the doctor should know about? ☐ Yes ☐ No
11. Women : Are you Pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

DENTAL HISTORY

1. Reason for today's visit: ☐ Exam ☐ Cleaning ☐ Dental Emergency ☐ Dental Pain ☐ Other
2. Is there a dental problem you would like to take care of as soon as possible? ☐ Yes ☐ No
   Please Specify _____
3. How frequently do you visit your dentist? ☐ 3-6Month ☐ Annually Other _____
4. Last dental Cleaning? ☐ Last dental visit? ☐ Last dental X-rays?
5. How often do you brush your teeth? _____ Floss? ☐ Yes ☐ No
6. Does your jaw crack or pop when opened widely? ☐ Yes ☐ No
7. Do you have any of the following? Please check any that apply: ☐ Yes ☐ No

☐ Braces	☐ Oral Surgery	☐ Gum treatment	☐ Root canal
☐ Bad Breath	☐ Bleeding Gum	☐ Jaw Pain / Migraine Headache	☐ Loose or Broken Teeth
☐ Loose or Broken Fillings	☐ Grinding Teeth	☐ Sores or Growth in the Mouth	☐ Missing Teeth
☐ Gum Recession	☐ Gum swollen/tender	☐ Teeth feel rough	☐ Teeth Stain

8. Are your teeth sensitive to : ☐ Hot ☐ Cold ☐ Biting ☐ Sweets
9. Do you smoke? Number per day _____ ☐ Yes ☐ No
10. Have you had any previous problems with dental treatment? Specify _____ ☐ Yes ☐ No
11. Are you nervous about dental appointments? ☐ Yes ☐ No
12. Have you ever experienced complications during dental treatment? ☐ Yes ☐ No
13. Would you like to learn about dental implants to replace missing teeth? ☐ Yes ☐ No
14. Have you ever been given oral hygiene instruction? ☐ Yes ☐ No

GENERAL RELEASE / CONSENT

I the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I understand that responsibility for payment for the dental services provided for myself and my dependants is mine, and I will assume responsibility for fees associated with these services at the end of each visit.

Signature ☐ Self ☐ Parent ☐ Guardian

Print Name _____ Signature _____

Date DD MM YYYY Reviewing Doctor _____

Thank You