Welcome To Markham NS Dental

So much begins with smile

Patient Information

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

Name: ______ (Last Name) (First Name) (Initial)

Prefer to be called: ______ Date Of Birth: ___/___/___ DD/MM/YYYY

Address: ______ (Street) (Apt #)

______ (City) (Province) (Postal Code)

Phone: Home: ( ) - ______ Work: ( ) - x ______

Cell: ( ) - ______ Best Phone : ☐ Home ☐ Work ☐ Cell

email: ______

Employer/School: ______ Occupation: ______

Are you available on short notice for appointments? ☐ Yes ☐ No Preferred time: ______

Family Physician: ______ Phone No: ( ) - ______

In Case of Emergency: ______ Notify Relationship Phone No:

Financial Information (If different from above)

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

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

Phone: home: ( ) - ______ work: ( ) - x ______

Primary Insurance

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

Relation: ☐ Self ☐ Spouse ☐ Other ______

Insurance Co: ______ Phone No: ______

Certificate / ID # ______ Policy / Plan / Group # ______

Division/Sect: ______

Are You Familiar with Your Plan details? ☐ Yes ☐ No ______

Secondary Insurance

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

Relation: ☐ Self ☐ Spouse ☐ Other ______

Insurance Co: ______ Phone No: ______

Certificate / ID # ______ Policy / Plan / Group # ______

Division/Sect: ______

Are You Familiar with Your Plan details? ☐ Yes ☐ No ______

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

☐Another Patient, ☐Friend, ☐ Relative, ☐ Professional ☐ Staff Member ______ Name

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 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 hospitalized in the last 5 years? Specify: ____ ☐ Yes ☐ No
8. Have you been warned against taking any drug or medication? ☐ Yes ☐ No
9. Do you bruise easily or bleed abnormally? ☐ Yes ☐ No
10. Have you ever had any organ implants or medical implants? ☐ Yes ☐ No
11. Have you ever fainted? ☐ Yes ☐ No
12. Do you experience shortness of breath or chest pain when walking or climbing stairs? ☐ Yes ☐ No
13. Do you have any of the following? Please check any that apply:

☐ 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	☐ Other

14. Have you had any injury, surgery or x-ray therapy to your face or jaws? ☐ Yes ☐ No
15. Do you have any disease, condition or problem that you think the doctor should know about? ☐ Yes ☐ No
16. Are you pregnant or suspect you might be? If so What month are you in? ____ ☐ Yes ☐ No
17. Are you taking birth control pills? ☐ Yes ☐ No
18. Are you nursing? ☐ Yes ☐ No

DENTAL HISTORY

1. Reason for today's visit: ☐ Exam ☐ Cleaning ☐ Emergency ☐ Other ____
2. Are you presently having dental pain? ☐ Yes ☐ No
3. Is there a dental problem you would like to take care of as soon as possible? ☐ Yes ☐ No
   Please Specify ____
4. How frequently do you visit your dentist? ☐ 3-6Month Annually ☐ Other ____
5. Last Cleaning? ____ Last dental visit? ____ Last X-rays? ____
6. Does food get caught between your teeth? ☐ Yes ☐ No
7. Do you have pain in your jaw joints or suffer from migraine headaches? ☐ Yes ☐ No
8. Does your jaw crack or pop when opened widely? ☐ Yes ☐ No
9. Have you had ☐ Braces ☐ Oral Surgery ☐ Gum treatment ☐ Root canal
10. Are your teeth sensitive to : ☐ Hot ☐ Cold ☐ Biting ☐ Sweets ☐ Yes ☐ No
11. Do you grind or clench your teeth during the day or night? ☐ Yes ☐ No
12. Do you smoke? Number per day ____ ☐ Yes ☐ No
13. Have you ever experienced any growth or sore spots in your mouth? If so where? ____ ☐ Yes ☐ No
14. Have you had any previous problems with dental treatment? Specify ____ ☐ Yes ☐ No
15. Are you nervous about dental appointments? ☐ Yes ☐ No
16. Have you ever experienced complications during dental treatment? ☐ Yes ☐ No
17. Do you have missing teeth? ☐ Yes ☐ No
18. Would you like to learn about dental implants to replace missing teeth? ☐ Yes ☐ No
19. Have you experienced gum recession on any of your teeth? ☐ Yes ☐ No
20. How often do you brush your teeth? ____ Floss? ____
21. Do you feel you have bad breath at times? ☐ Yes ☐ No
22. Do your gums feel swollen or tender? ☐ Yes ☐ No
23. Do your gums bleed easily? ☐ Yes ☐ No
24. Do your teeth feel rough (not smooth)? ☐ Yes ☐ No
25. Have you ever been given oral hygiene instruction? ☐ Yes ☐ No
26. Do your teeth stain easily? ☐ Yes ☐ No
27. Are your teeth sensitive during brushing? ☐ Yes ☐ No

GENERAL RELEASE / PATIENT 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 ____