YOUFIRSTDENTAL
Everyone is important

Patient Information (confidential)

Date: _____

First Name: _____ Last Name: _____

Birthdate: _____ Gender: ○ Male ○ Female

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Email: _____

All appointments must be confirmed. How would you like to be contacted?

☐ Email ☐ Text ☐ Phone Call

Person to contact in case of emergency: _____ Phone: _____

How did you find out about us? _____

_____

_____

Insurance Information

Name of Policy Holder: _____ Birthdate: _____

Policy Holder's Employer: _____ Name of Insurance Company: _____

Group/Policy # _____ ID# _____

Do you have additional Insurance? ○ Yes ○ No

If yes, please complete the following:

Name of Policy Holder: _____ Birthdate: _____

Policy Holder's Employer: _____ Name of Insurance Company: _____

Group/Policy # _____ ID# _____

Please Note The Following

As a courtesy to you, our office will submit your claim directly to your insurance company for payment whenever possible. To allow us to provide this service to our patients we require a credit card number to be kept on file in the event of any portion not covered by insurance.

Credit Card # _____ Expiry Date: _____

A service charge of 2% per month will be charged on all unpaid balances exceeding 90 days, unless a financial arrangement has previously been made. Any other collection or legal charges that may be incurred in this regard are also the responsibility of the patient.

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Patient Dental History

Name of Previous Dentist: _____ Date of Last Exam: _____

1. Do your gums bleed when brushing or flossing? ○ Yes ○ No
2. Are your teeth sensitive to hot or cold temperature? ○ Yes ○ No
3. Are your teeth sensitive to sweet or sour liquids/foods? ○ Yes ○ No
4. Do you feel pain in any of your teeth? ○ Yes ○ No

If yes, please explain: _____

_____

5. Do you have any sores or lumps in or near your mouth? ○ Yes ○ No
6. Have you had any head or neck injuries? ○ Yes ○ No

If yes, please explain: _____

_____

7. Have you experienced any of the following problems in your jaw? (Check all that apply)

☐ Clicking ☐ Pain (joint, ear, side of face) ☐ Difficulty in opening or closing ☐ Difficulty in chewing

8. Do you have frequent headaches? ○ Yes ○ No If yes, how often? _____
9. Do you clench or grind your teeth? ○ Yes ○ No
10. Have you had any difficult extractions in the past? ○ Yes ○ No
11. Have you ever had any prolonged bleeding following extractions? ○ Yes ○ No
12. Have you had any orthodontic treatment? ○ Yes ○ No
13. Do you wear dentures or partials? ○ Yes ○ No
14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ○ Yes ○ No
15. Do you like your smile? ○ Yes ○ No

Patient Sleep History

1. Have you ever had a sleep study or been told to get one? ○ Yes ○ No
2. Have you ever been diagnosed with a sleep disorder? ○ Yes ○ No
3. Do you wake up in the morning feeling unrefreshed? ○ Yes ○ No
4. Are you a restless sleeper? ○ Yes ○ No
5. Do you catch yourself nodding off during the day (at times when you shouldn't be?) ○ Yes ○ No
6. Does your bed partner sleep in another room because of your snoring? ○ Yes ○ No
7. Do you have dry mouth or a sore throat when you wake up? ○ Yes ○ No
8. Have you ever used a CPAP machine? ○ Yes ○ No
9. Are you currently using a CPAP machine? ○ Yes ○ No
10. Have you tried CPAP and are looking for other treatment choices? ○ Yes ○ No

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Patient Medical History

1. Are you under medical treatment now? ○ Yes ○ No

If yes, please explain: _____

2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years? ○ Yes ○ No

If yes, please explain: _____

3. Are you taking any medications including non-prescription medicine? ○ Yes ○ No

If yes, what medications are you taking? _____

4. Have you ever taken Fen-Phen/Redux? ○ Yes ○ No

5. Do you require pre-medication for dental appointments? ○ Yes ○ No

If yes, please explain: _____

6. Have you ever had difficulty freezing? ○ Yes ○ No

If yes, please explain: _____

7. Do you have or have you had any of the following? (Check all that apply)

- ☐ Anemia
- ☐ Angina
- ☐ Arthritis (List type)
- ☐ Asthma
- ☐ Cancer (List type)
- ☐ Cardiac Pacemaker
- ☐ Chest Pains
- ☐ Contraceptive Use
- ☐ Convulsions
- ☐ Creutzfeld-Jakob disease
- ☐ Diabetes (List type)
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injury
- ☐ Hearing Disabled
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A, B or C (List type)
- ☐ Jaundice
- ☐ Joint Replacement (Date of)
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease (List type)
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Mental Disorder (List type)
- ☐ Multiple Sclerosis
- ☐ Nervous Disorder (List type)
- ☐ Radiation Therapy
- ☐ Respiratory Problems (List type)
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ STD (List type)
- ☐ Stomach Troubles (List type)
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ Thyroid Problem (List type)
- ☐ TMJ Problem
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other

8. Are you allergic to or have you had a reaction to any of the following? (Check all that apply)

- ☐ Any Metals (i.e. nickel, mercury, etc.)
  (List type) _____
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Iodine
- ☐ Local Anesthetics (i.e. Novocaine.)
- ☐ Penicillan
- ☐ Other Antibiotics (List type)
- ☐ Sedatives
- ☐ Sulfa Drugs
- ☐ Other

9. Women Only: Are you pregnant? ○ Yes ○ No Are you Nursing? ○ Yes ○ No

AUTHORIZATION AND RELEASE

I certify that I have read and understand all of the information in this form to the best of my knowledge. All of the preceding questions pertaining to my Personal Information, Insurance Information and Medical & Dental History have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the third party pay or sand/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all records of any treatment or examination rendered to me or my child during the period of such dental care to services rendered on my behalf or my dependents. I authorize the dentist to submit my insurance claims electronically on my behalf.

_____

Signature of patient (or guardian if minor)