



Patient Information (confidential)

Date: _____

First Name: _____ Last Name: _____

Birthdate: _____ Gender: Male Female Other

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

Address: _____

City: _____ Province: _____ Postal Code: _____

Email: _____

If patient is a minor: Parent / Guardian Information

First Name: _____ Last Name: _____

Address (if different from above) _____

City: _____ Province: _____ Postal Code: _____

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

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? Google Instagram Facebook Other; OR

Who can we thank for referring you to our clinic? _____

Insurance Information

We kindly ask you to update our office with a current credit card if your card on file expires or is cancelled. Any credit card left on file will be used for all members on the account unless specified below.

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# _____

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.

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: _____

Name on Card: _____

This Credit card may only be used for: _____

Dental Insurance Submissions

We extend the courtesy of sending most insurance claims electronically. Due to the Canadian Personal Privacy Act, the details of your dental insurance plan are kept confidential. We are unable to access this information. Please be informed of the details of your dental plan that were provided to you by your insurer. It is your responsibility to know these details, including maximums, frequencies and any other limitations. We are happy to assist you if you have any questions.

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 | |

Patient Medical History

- | | | |
|---|-----|----|
| 1. Are you under medical treatment now? | Yes | No |
|---|-----|----|

If yes, please explain: _____

If yes, Physician's Name: _____ Physician's Phone Number: _____

- | | | |
|--|-----|----|
| 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? (Please include non prescription supplements or medical marijuana)

- | | | |
|---|-----|----|
| 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)

ADHA	Drug / Alcohol Dependency	Leukemia	Rheumatic Fever
Anemia	or Recovery	Liver Disease (List type)	Seizures
Angina / Chest Pain	Easily Winded	_____	Sleep Problems (Please check)
Arthritis (List type)	Emphysema	Low Blood Pressure	Sleep Apnea
_____	Epilepsy	Lung Disease	Snoring
Autoimmune	Fainting/Dizziness	Mitral Valve Prolapse	Sinus
Asthma	Glaucoma	Mental Disorder (List type)	Insomnia
Bleeding problems/disorders	Hay Fever	_____	Smoke or Chew Tobacco
Blood Pressure problems	Head Injury	Multiple Sclerosis	STD (List type) _____
Cancer (List type)	Hearing Disabled	Nervous Disorder (List type)	Steroid Therapy
_____	Heart Attack	_____	Stomach Troubles (List type)
Cardiac Pacemaker	Heart Disease	Osteoporosis	Stroke
Chemotherapy	Heart Murmur	Pacemaker	Swollen Ankles
Chest Pains	Hepatitis A, B or C (List type)	Psychiatric Treatment	Thyroid Disease (List type)
Contraceptive Use	_____	Prosthetic or artificial joint	_____
Convulsions	Jaundice	Prosthetic Heart	TMJ Problem
Depression	Joint Replacement (Date of)	Radiation Therapy	Tuberculosis
Diabetes (List type)	_____	Respiratory Problems (List type)	Ulcers
_____	Kidney Disease	_____	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.)	Codeine	Other Antibiotics (List type) _____
(List type) _____	Iodine	Sedatives
Aspirin	Local Anesthetics (i.e. Novocaine)	Sulfa Drugs
Barbiturates	Penicillin	Other _____

9. **WOMEN ONLY:** Are you pregnant? Yes No Are you Nursing? Yes No

10. Are there any other conditions not listed above that you currently have or have not had? Yes No

If yes, please explain: _____

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)