YOUFIRSTDENTAL
Everyone is important

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# _____

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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.

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

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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: _____

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

ADHA
Anemia
Angina / Chest Pain
Arthritis (List type)
_____
Autoimmune
Asthma
Bleeding problems/disorders
Blood Pressure problems
Cancer (List type)
_____
Cardiac Pacemaker
Chemotherapy
Chest Pains
Contraceptive Use
Convulsions
Depression
Diabetes (List type)
_____

Drug / Alchohol Dependancy or Recovery
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
Lung Disease
Mitral Valve Prolapse
Mental Disorder (List type)
_____
Multiple Sclerosis
Nervous Disorder (List type)
_____
Osteoporosis
Pacemaker
Psychiatric Treatment
Prosthetic or artificial joint
Prosthetic Heart
Radiation Therapy
Respiratory Problems (List type)
_____

Rheumatic Fever
Seizures
Sleep Problems (Please check)
- Sleep Apnea
- Snoring
- Sinus
- Insomnia

Smoke or Chew Tobacco
STD (List type) _____
Steroid Therapy
Stomach Troubles (List type)
Stroke
Swollen Ankles
Thyroid Disease (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

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)