YOUFIRSTDENTAL
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MEDICAL UPDATE

Patient Information (confidential)

Name: _____ Date: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

What is your preferred option to be contacted?

☐ Email ☐ Text ☐ Phone Call

Patient Medical History

1. Are you under medical treatment now? If yes, please explain. ◉ Yes ◉ No

_____

2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain. ◉ Yes ◉ No

_____

3. Are you taking any medications including non-prescription medicine? If yes, please provide. ◉ Yes ◉ No

_____

4. Do you require pre-medication for dental appointments? If yes, please explain. ◉ Yes ◉ No

_____

5. Have you ever had difficulty freezing? If yes, please explain. ◉ Yes ◉ No

_____

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

☐ Angina
☐ Arthritis (list type) _____
☐ Asthma
☐ Cancer (list type) _____
☐ Cardiac Pacemaker _____
☐ Chest Pains
☐ Convulsions
☐ Diabetes (list type)
☐ Fainting / Dizziness
☐ Heart Attack (date) _____
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis A, B or C (list type) _____
☐ High Blood Pressure
☐ Joint Replacement (date) _____
☐ Kidney Disease
☐ Liver Disease (list type) _____
☐ Low Blood Pressure
☐ Mental Disorder (list type) _____
☐ Nervous Disorder (list type) _____
☐ Pregnancy
☐ Respiratory Problems (list type) _____

Patient Dental History

1. Have you ever been told you have gum disease? ◉ Yes ◉ No

2. Are your teeth sensitive to any of the following? (Check all that apply)

☐ Hot ☐ Cold ☐ Sweet ☐ Sour ☐ Biting

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

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

4. Do you have frequent headaches? ◉ Yes ◉ No If yes, how often? _____

Do you take any medication for your headaches? ◉ Yes ◉ No If yes, please list: _____

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Patient Dental History continued

6. Have you had any orthodontic treatment? ○ Yes ○ No

7. Are you happy with your smile? ○ Yes ○ No

8. Do you snore? ○ Yes ○ No

9. History of Tonsil, Adenoid or Nasal Surgery ○ Yes ○ No

Are you allergic to or sensitive to any of the following? (Check all that apply)

- ☐ Any Metals (i.e. nickel, mercry, etc.) (list type) _____
- ☐ Codeine
- ☐ Latex Rubber
- ☐ Local Anesthetics (i.e. Novocaine)
- ☐ Penicillan
- ☐ Other Antibiotics (list type) _____
- ☐ Sedatives
- ☐ Sulfa Drugs
- ☐ Other _____

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 hte 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 wake up frequently to urinate during the night? ○ Yes ○ No

8. Do you grind your teeth at night? ○ Yes ○ No

9. Have you ever had jaw clicking / pain, tooth sensitivity, or been told you have TMD? ○ Yes ○ No

10. Do you have a dry mouth or sore throat when you wake up? ○ Yes ○ No

11. Have you ever used a CPAP machine? ○ Yes ○ No

12. Are you currently using a CPAP machine? ○ Yes ○ No

If yes, do you use your CPAP less than 5 times per week? ○ Yes ○ No

13. Have you tried CPAP and are looking for other treatment choices? ○ 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)