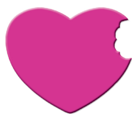

YOUFIRSTDENTAL
Everyone is important

Patient Information (confidential)

Date

Name

Birthdate Male Female

Home Ph

Cell Ph Work Ph

Address

City 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 of Emergency

Phone #

How did you find out about us?

Insurance In formation

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.

Patient Dental History

Name of Previous Dentist

Date of Last Exam

Yes No

1. Do your gums bleed while brushing or flossing?
2. Are your teeth sensitive to hot or cold temperatures?
3. Are your teeth sensitive to sweet or sour liquids/foods?
4. Do you feel pain in any of your teeth?

If Yes, please explain

5. Do you have any sores or lumps in or near your mouth?
6. Have you had any head or neck injuries?

If Yes, please explain

7. Have you experienced any of the following problems in your jaw?
   - Clicking
   - Pain (joint, ear, side of face)
   - Difficulty in opening or closing
   - Difficulty in chewing

Yes No

8. Do you have frequent headaches?

If Yes, how often?

Do you take any medication for your headaches?

If Yes, please list:

9. Do you clench or grind your teeth?
10. Have you had any difficult extractions in the past?
11. Have you ever had any prolonged bleeding following extractions?
12. Have you had any orthodontic treatment?
13. Do you wear dentures or partials?

Date of placement

14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?
15. Do you like your smile?

Patient Medical History

1. **Are you under medical treatment now?** **Y** **N**

   If Yes, please explain

2. **Have you been hospitalized for any surgical operation or serious illness within the last 5 years?** **Y** **N**

   If Yes, please explain

3. **Are you taking any medications including non-prescription medicine?** **Y** **N**

   If Yes, what medications are you taking?

4. **Have you ever taken Fen-Phen/Redux?** **Y** **N**

5. **Do you require pre-medication for dental appointments?** **Y** **N**

   If Yes, please explain

6. **Have you ever had difficulty freezing?** **Y** **N**

   If Yes, please explain

7. **Do you have or have you had any of the following?**

	Yes	No
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)		
High Blood Pressure		

	Yes	No
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:**

	Yes	No
Any Metals (i.e. nickel, mercury, etc.) (List type)		
Aspirin		
Barbiturates		
Codeine		
Iodine		
Latex Rubber		

	Yes	No
Local Anesthetics (i.e. Novocaine.)		
Penicillan		
Other Antibiotics (List type)		
Sedatives		
Sulfa Drugs		
Other		

9. **Women Only:**

	Yes	No
Are you Pregnant?		
Are you Nursing?		

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.

X ______________________________

Signature of patient (or guardian if minor)