Health First DENTAL

Name_____ Preferred Name _____
Birthdate(dd/mm/yy) _____ Age_____ Marital Status _____ Spouse's Name _____
Address_____
City _____ Province_____ Postal Code _____
Phone #(Home) _____ (Work)_____ (Cell)_____
E-mail _____
Occupation _____Employer_____
Whom may we thank for referring you to our practice? _____

Health History

Physician's Name _____ Phone # _____ Date of Last Visit? _____
Alternative Healthcare Provider's Name (i.e. Naturopath, Osteopath, etc.) _____
Please list the following:

- Allergies (i.e. drugs, metals, latex?) _____
- Prescription medications/dosage _____
- Supplements or over the counter medications including aspirin _____

Hospitalization or emergency care during the last 5 years? Reason? _____

Indicate which of the following you have had or have at present. (Please check those that apply):

- □ AIDS/HIV Positive
- □ Anemia
- □ Arthritis
- □ Artificial Joints
- □ Asthma
- □ Bleeding Disorders
- □ Cancer
- □ Diabetes
- □ Epilepsy
- □ Fainting
- □ Glaucoma
- □ Hay Fever
- □ Heart Disease
- □ Heart Murmur
- □ Hepatitis A B C
- □ High Blood Pressure
- □ Kidney Disease
- □ Liver Disease
- □ Lung Disease
- □ Lyme Disease
- □ Mental Disorders
- □ Nervous Disorders
- □ Osteoporosis
- □ Pacemaker
- □ Radiation Treatment
- □ Rheumatic Fever
- □ S.T.D's
- □ Sinus Problems
- □ Sleep Apnea
- □ Stroke
- □ Tuberculosis
- □ Thyroid Disease
- □ Other:_____

Do you smoke tobacco? _____ How much per day? _____ How many years? _____
Do you smoke e-cigarettes? _____ How much per day? _____ How many years? _____
Do you smoke cannabis? _____ How much per day? _____ How many years? _____
Do you consume alcohol? _____ How often? _____
Do you use recreational or street drugs? _____ Have you had a blood transfusion? _____

WOMEN: Are you pregnant or think you could be pregnant? _____ Due Date_____
Are you nursing? _____
Do you use birth control prescriptions? _____

Dental History

Previous Dentist _____ Reason for Leaving _____
How often do you visit the dentist? _____ Date of last visit _____ Last X-rays _____
Oral Hygiene Habits:

- How often do you brush/day _____ Floss/day _____ Mouth rinse/day _____

Teeth Condition: _

- Are your teeth sensitive to Heat? _____ Cold? _____ Sweets? _____ Chewing pressure? _____
- Have you ever had teeth removed? _____ When? _____
- Have you had orthodontic treatment? _____ When? _____ Do you wear a retainer? _____

Gum Condition:

- Do your gums bleed with brushing? _____ Flossing? _____ Do you have bad breath? _____
- Have your parents experienced gum disease or tooth loss? _____

Jaw Condition:

- Do you have clicking, popping, or pain in your jaw? _____ Do you clench/grind your teeth? _____
- Headaches? _____ Jaw muscle stiffness in the morning? _____

Are you nervous or uneasy about having dental treatment? _____
Are you satisfied with your smile? _____ What would you change? _____
What is your immediate concern? _____

To the best of my knowledge the above information is correct. If I ever have any change in my health, I will inform the doctor or hygienist at my next appointment without fail.

_____ _____
Signature of patient, parent, or guardian Date

So we can best meet your oral health objectives, please check all that apply:
I am interested to learn about:

- □ How oral health affects general health
- □ The dangers of silver (mercury) fillings
- □ The link between gum disease and heart disease
- □ Laser gum therapy
- □ The benefits of digital x-rays
- □ Dental implants
- □ Straightening teeth with Invisalign
- □ Cosmetic dentistry
- □ Teeth Whitening
- □ Other _____

Insurance Information

Primary Insurance Company	**Secondary Insurance Company**
Subscriber:	Subscriber:
Relationship to Subscriber:	Relationship to Subscriber:
Birthdate of Subscriber:	Birthdate of Subscriber:
Group/Policy #:	Group/Policy #:
ID/Cert #:	ID/Cert #:
Employer:	Employer: