Clinton
DENTISTRY

New Patient Health History Form

Patient's Name:

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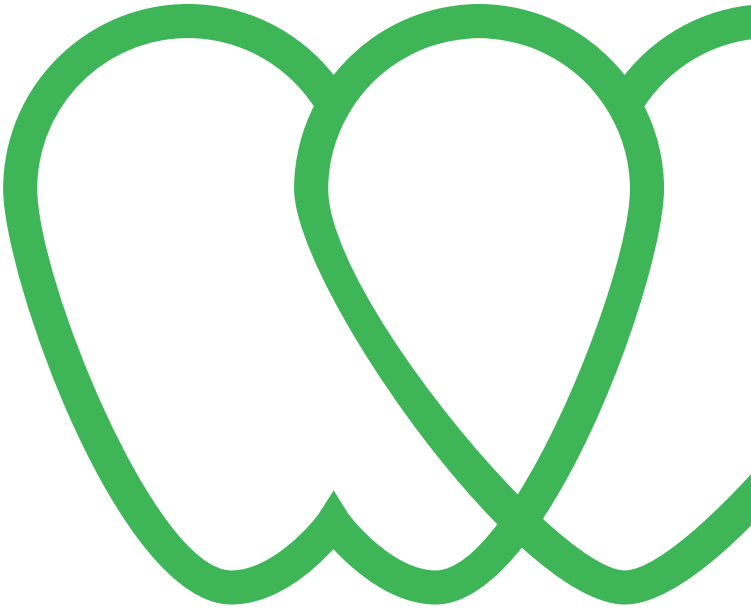

Patient Information

◉ Mr. ○ Mrs. ○ Dr. ○ Ms. ○ Miss | ○ Married ○ Single ○ Divorced ○ Widowed

Patient's Name: _____ Address: _____

Age: _____ _____

Date of Birth: _____ City / Province: _____

○ Male ○ Female Postal Code: _____

Employed By: _____ Home Phone: _____

Work Phone: _____ Email Address: _____

Emergency Contact: _____ Phone: _____

Patient Guardian Information

If the patient is a minor, please fill out the box below:

○ Parent ○ Guardian

Address: _____ City / Province: _____

_____ Postal Code: _____

Who may we thank for referring you to our office? _____

Insurance Information

We are a "fee for service" office and require payment at the time of service, therefore, we will gladly provide you with any information required each visit to make claim to your insurance company for reimbursement. Please let us know if you have any questions.

Insurance Company: _____ Insured's Name: _____

Group Number: _____ Insured's Date of Birth: _____

ID #: _____ Employer Name: _____

Phone Number: _____

I certify that the information in this document is correct to the best of my knowledge.

Parent/Guardian Signature: _____ Date: _____

Medical History

Please answer the following questions as completely and accurately as you can. Also, please be as detailed as possible providing additional information you think is important. If you have any questions about this form, or your upcoming appointment, contact our office for assistance.

Please select **yes** or **no**. If yes, please explain on the lines provided.

Yes	No			
◯	◯	1.	Do you have a current medical problem?	_____
◯	◯	2.	Have you been told you have a heart murmur?	_____
◯	◯	3.	Do you have any heart problems? What kind?	_____
◯	◯	4.	Do you have high or low blood pressure?	◯ High Blood Pressure ◯ Low Blood Pressure
			How is it controlled?	_____
◯	◯	5.	Have you had rheumatic fever? When?	_____
◯	◯	6.	Have you had pain in your chest or shortness of breath?	_____
◯	◯	7.	Do your ankles swell?	_____
◯	◯	8.	Has you physician ever told you that you are anemic?	_____
◯	◯	9.	Have you ever had a stroke? When?	_____
◯	◯	10.	Have you ever had epilepsy?	_____
◯	◯	11.	Do you have diabetes? Is it controlled?	_____
◯	◯	12.	Do you have fainting or dizzy spells?	_____
◯	◯	13.	Do you feel like your sense of balance has changed?	_____
◯	◯	14.	Do you have headaches? How often? Where?	_____
◯	◯	15.	Do you take Aspirin, Advil, Tylenol or another pain reliever? How often?	_____
◯	◯	16.	Have you been advised not to take any medication? What?	_____
◯	◯	17.	Do you have asthma or hay fever? How is it controlled?	_____
◯	◯	18.	Have you ever had tuberculosis? When?	_____
◯	◯	19.	Have you ever had glaucoma? When?	_____

Yes	No			
○	○	20.	Have you ever had hepatitis? When?	
○	○	21.	Do you have arthritis? How is it controlled?	
○	○	22.	Have you ever had a tumor or cancer? How was it treated?	
○	○	23.	Have you ever had any major surgeries? What kind?	
○	○	24.	Have you ever been injured in an accident? When?	
○	○	25.	Have you ever had a severe blow to the head? When?	
○	○	26.	Are your hands and/or feet cold? How often?	
○	○	27.	Is your diet medically supervised? For what purpose?	
○	○	28.	Do you have difficulty swallowing?	
○	○	29.	Do you have a feeling of something stuck in your throat?	
○	○	30.	Do you ever have any facial pain or pressure? Where?	
○	○	31.	Do you ever have any pain or pressure behind your eyes?	
○	○	32.	Are you aware of stiff neck muscles? How often?	
○	○	33.	Have you been in traction for a neck injury? When?	
○	○	34.	Have you ever had or been advised to have neck surgery?	
○	○	35.	Do you have back pain? Where?	
○	○	36.	Do your ears feel itchy, stuffy or congested?	
○	○	37.	Do you have difficulty with pain in your ears when changing altitude?	
○	○	38.	Do your ears ring, buzz or hiss? How often?	
○	○	39.	Have you noticed any changes in your hearing?	
○	○	40.	Are you depressed?	
○	○	41.	Do you have emotional or anxiety/nervous problems?	

Yes	No			
◯	◯	42.	Have you ever been treated for emotional or anxiety/nervous problems?	_____
◯	◯	43.	Have you gained or lost weight within the last year? Which: Weight: _____ Height: _____	◯ Gained weight ◯ Lost weight How much? _____
◯	◯	44.	Do you take more than one alcoholic drink per day? How many?	_____
◯	◯	45.	Do you use tobacco? How much?	_____
◯	◯	46.	Have you had any other serious illnesses, hospitalization or accidents? Please explain:	_____ _____

Please list ALL medications, including supplements, and the dosage you are currently taking:

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

Please list any allergies to any **medications**:

1. _____ 2. _____ 3. _____ 4. _____

Other allergies:

1. _____ 2. _____ 3. _____ 4. _____

Dental History

Yes	No			
		47.	When was your last dental visit?	_____
◯	◯	48.	Have you been told that you have periodontal (gum) disease?	_____
◯	◯	49.	Do you have any existing problems with your teeth? Describe:	_____
◯	◯	50.	Is any dental treatment planned? Describe:	_____
◯	◯	51.	Do you bite your nails?	_____
◯	◯	52.	Have you ever had oral surgery?	_____
◯	◯	53.	Have you lost any teeth? From what cause?	_____
◯	◯	54.	Have the teeth been replaced? When?	_____

Yes	No			
◯	◯	55.	Have you ever had orthodontic treatment? When?	
◯	◯	56.	Have you ever had extensive dental treatment? When?	
◯	◯	57.	Is any part of your mouth sensitive to temperature, pressure, food or drink? Where?	
◯	◯	58.	Do you wear dentures or partial dentures? Are they comfortable?	

TMJ History

Yes	No			
◯	◯	59.	Do you ever have a burning or painful sensation in your mouth?	
◯	◯	60.	Do you get popping, clicking, or grinding noises when you open or close?	
◯	◯	61.	Do you ever awaken with an awareness of your teeth or jaws?	
◯	◯	62.	Are you aware of clenching during the daytime? How often?	
◯	◯	63.	Have you ever been told you grind your teeth during sleep?	
◯	◯	64.	Do you have trouble opening your mouth widely?	
◯	◯	65.	Does your jaw ever lock open or closed? How often?	
◯	◯	66.	Do you feel your bite is different, unstable or uncomfortable?	
		67.	What professional advice or treatment have you had regarding your head, neck or facial pain?	
◯	◯	68.	If you sought treatment for a TMJ problem, did it help?	
◯	◯	69.	Do you or have you had any pain in any of the following areas?	

◯ Jaw ◯ Ear

◯ Face ◯ Neck

◯ Teeth ◯ Head

◯ Other: _____

◯	◯	70.	Do your jaw problems affect your ability to chew?	

Yes	No			
◯	◯	71.	Has your diet changed due to your jaw problems? Describe:	_____

Family History

Yes	No			
◯	◯	72.	Do you have children? What are their ages?	_____
		73.	Current level of stress:	◯ Mild ◯ Moderate ◯ Severe

For Women

Yes	No			
◯	◯	74.	Are you pregnant? Expected delivery date:	_____
◯	◯	75.	Do you have a history of miscarriages? When?	_____
◯	◯	76.	Have you reached menopause?	_____

Sleep, Snoring, and Apnea History

Yes	No			
◯	◯	77.	Do you become easily fatigued? At what time of day?	_____
◯	◯	78.	Do you have problems with insomnia?	_____
◯	◯	79.	Do you sleep well? How long?	_____
◯	◯	80.	Do you dream? How often?	_____
◯	◯	81.	Do you have trouble falling asleep or staying asleep? Which:	_____
◯	◯	82.	Do you snore or have you been told you do?	_____
◯	◯	83.	Do you wake up with a headache?	_____
◯	◯	84.	Have you had chronic sleepiness, fatigue or weariness that you can't explain?	_____
◯	◯	85.	Do you often fall asleep reading or watching television?	_____
◯	◯	86.	Have you fallen asleep during the day against your will?	_____

Yes	No			
◯	◯	87.	Have you had to pull off the road while driving due to sleepiness?	_____
◯	◯	88.	Have you been more irritable and short tempered?	_____
◯	◯	89.	Have you felt that your memory and/or intellect is impaired?	_____
◯	◯	90.	Have you been told that you stop breathing while asleep?	_____
◯	◯	91.	About how many times per night do you wake up?	_____
		92.	What time do you normally go to bed?	_____
			Get up in the morning?	_____
		93.	Of the hours you are in bed, about how many hours are you asleep?	_____
		94.	Would you rate the quality of your sleep as:	◯ Good ◯ Fair ◯ Poor
◯	◯	95.	Do you have difficulty breathing through your nose?	_____
◯	◯	96.	Have you been diagnosed or treated for a sleep disorder? When:	_____
◯	◯	97.	Have any immediate family members been diagnosed or treated for a sleep disorder?	
◯	◯	98.	Have you ever had an evaluation at a sleep center?	
			Sleep Center Name:	_____
			Location:	_____
			Sleep Study Date:	_____
		99.	What professional advice or treatment have you received about your snoring or sleep apnea?	_____ _____
◯	◯	100.	If you sought treatment for a sleep disorder, did it help?	_____ _____

Sleeping Situations

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life recently.

Use the following scale and choose the most appropriate number for each situation:

0 = Would **never** doze

1 = **Slight** chance

2 = **Moderate** chance of dozing

3 = **High** chance of dozing

_____ Sitting and reading
_____ Watching TV
_____ Sitting inactive in a public place (e.g. A theater or a meeting)
_____ As a passenger in a car for an hour without a break
_____ Lying down to rest in the afternoon when circumstances permit
_____ Sitting and talking to someone
_____ Sitting quietly after a lunch without alcohol
_____ In a car, while stopped for a few minutes in traffic

CPAP Device

If you **have not** worn a CPAP device, **skip this section.**

Yes **No**

◯ ◯ Do you wear a CPAP device **successfully** during sleeping? _____

How many hours per night do you wear your CPAP? _____

◯ ◯ Have you tried other therapies for your sleeping disorder? Please list other therapies (weight-loss attempts, smoking cessation, surgeries, appliances, etc.) _____ _____

CPAP Difficulties

If you are unable to wear a CPAP device, please check below the reasons for your difficulty.

◯ Mask leaks
◯ Mask uncomfortable/device uncomfortable
◯ Unable to sleep comfortably
◯ Noise disturbs my sleep and/or my partner's sleep
◯ Restricts movement during sleep
◯ Does not seem to be effective
◯ Straps/headgear cause discomfort
◯ Pressure on the upper lip causes tooth related problems
◯ Latex allergy
◯ Claustrophobia
◯ Other: _____

Nutrition

Which type of diet do you follow?

- ◯ Vegan _____
- ◯ Vegetarian _____
- ◯ Paleo _____
- ◯ Canada Food Guide _____
- ◯ Other _____

How often do you eat fast food: Week:_____ Day:_____

Do you have any questions about diet & nutrition? _____

Would you like to speak to Sue, a Registered Holistic Nutritionist? _____

Complaints For Seeking Treatment

What are the chief complaints for which you are seeking treatment? Please order your chief complaints by number: **1** being the 1st or most important, **2** being the 2nd important, **3** being the 3rd less important, **4, 5, 6, etc. List only those that apply.**

Chief Complaint	Order	For Office Use Only
Jaw clicking/popping		
Jaw joint noises		
Jaw locking		
Muscle twitching		
Limited mouth opening		
Dizziness		
Headaches		
Visual disturbances		
Jaw pain		
Facial pain		
Ear pain		
Back pain		
Eye pain		
Neck pain		
Shoulder pain		
Pain when chewing		
Throat pain		
Ear congestion		
Sinus congestion		
Ringing in the ears		
Fatigue		
Frequent heavy snoring		
Snoring which affects the sleep of others		
Significant daytime drowsiness		
Stop breathing when sleeping		
Difficulty falling asleep		
Gasping when waking up		
Nighttime choking spells		
Feeling unrefreshed upon waking		
Morning hoarseness		
Swelling in ankles or feet		
Other: _____		
Other: _____		

When did your symptoms first start?

Was there a specific incident, accident or injury that seemed to trigger your symptoms?

Do your present symptoms affect relationships with family and friends? If so, how?

What are your expectations in seeking treatment at this time?

What do you see yourself doing after treatment that you are not able to do now?

Please use this space to tell us anything about your condition(s) that were not mentioned in this questionnaire:

Professional References

To better coordinate your treatment, please list the professionals you have consulted regarding your present symptoms. Please be sure to list your primary physician and other health practitioners. Please initial if you want us to send them a report from your visit.

Family Physician

Name: _____

Address: _____

Phone: _____

Initial: _____

Other

Name: _____

Address: _____

Phone: _____

Initial: _____

○ I understand and agree to have the indicated professionals I have listed above be sent initial information and ongoing updates regarding my diagnoses and treatment.

○ I do not wish to have my records sent at this time.

Partner Survey

To help us with a proper diagnosis and appropriate treatment plan, have your partner, if applicable and available, fill out this questionnaire regarding **your** sleep habits. This information is vitally important for Dr. Clinton to best evaluate your current condition. **This is to be filled out by the patient's partner.**

Patient's Name: _____

Yes	No		
◯	◯	1.	Do you witness your partner snoring? _____
◯	◯	2.	Do you witness your partner choking or gasping for breath during sleep?
◯	◯	3.	Does your partner pause or stop breathing during sleep? _____
◯	◯	4.	Does your partner fall asleep easily, if given the opportunity, during the day (normal wakeful hours)? _____
◯	◯	5.	Do you witness your partner clenching and/or grinding his/her teeth during sleep?
◯	◯	6.	Does the your partner refreshed upon waking? _____
◯	◯	7.	Do your partner sleep habits disturb your sleep? _____
◯	◯	8.	Does your partner sit up in bed, not awake? _____

9. Please check those sleep habits of your partner that are disturbing to you:

◯ Snores	◯ Biting tongue	◯ Restless
◯ Wakes up often	◯ Kicking during sleep	◯ Bed-wetting
◯ Stops breathing	◯ Head rocking/banging	◯ Grinds teeth
◯ Sleep walking	◯ Becoming very rigid or shaking	
◯ Loud gasping for breath while sleeping	◯ Sleep talking	◯ Other: _____

Sleeping Situations

How likely is your partner to doze off or fall asleep in the following situations, in contrast to just feeling tired?
Use the following scale and choose the most appropriate number for each situation:

_____ Sitting and reading
_____ Watching TV
_____ Sitting inactive in a public place (e.g. A theater or a meeting)
_____ As a passenger in a car for an hour without a break
_____ Lying down to rest in the afternoon when circumstances permit
_____ Sitting and talking to someone
_____ Sitting quietly after a lunch without alcohol
_____ In a car, while stopped for a few minutes in traffic

0 - Would **never** doze
1 - **Slight** chance
2 - **Moderate** chance of dozing
3 - **High** chance of dozing

Partner's Signature: _____ Date: _____

Office Policies

Please take a moment to read our office policies and feel free to ask any questions you may have.

Consent For Treatment

I hereby authorize Clinton Dentistry and designated staff to take x-rays, study models, photographs, electro-diagnostic studies and other diagnostic aids mutually agreed upon and deemed appropriate to make a thorough diagnosis.

Upon such diagnosis, I authorize Clinton Dentistry and staff to perform all recommended treatment mutually agreed upon by me and to employ such professional assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I authorize the release of a full report of examination findings, diagnosis, treatment program and ongoing progress report to any referring dentist, physician, chiropractor or other health care professionals as indicated previously. I additionally authorize the release of any medical information to insurance companies for legal documentation to process predeterminations and claims. **I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.**

Financial Policy

Payment is expected the day of your procedure as outlined verbally and/or in the written financial arrangement. We accept cash, Master Card/Visa Debit. For our patients carrying medical insurance, we do not accept assignment of benefits. However, we are happy to assist you with your insurance billing as a courtesy, though financial responsibility lies with you. Please ask our Patient Coordinators about your insurance issues.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received as agreed, I understand that a late charge of 1.5% on monthly balances will be added to my account and my account may be turned over for legal collection of any overdue amount. Our goal is to eliminate "billing surprises" so let us help you plan your treatment carefully by addressing your financial concerns before treatment begins.

Appointments

Should you need to cancel an appointment, we ask that you notify our office at least **24 business hours in advance.** If you fail to cancel your appointment appropriately or do not show up for your scheduled appointment, you will be charged a broken appointment fee of **$100.**

I have read and understand the Clinton Dentistry Consent for Treatment, Financial and Appointment policies. I have had all of my questions regarding these issues answered by a Patient Coordinator and agree to abide by these policies.

Patient's Name: _____ Date: _____

Parent/Responsible Party Signature: _____ Date: _____

Relationship: _____ Witness: _____