



New Patient Health History Form

Patient's Name:

Dr. Yasin Polara & Associates

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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**

- | | | | | |
|-----------------------|-----------------------|-----|--|-------|
| <input type="radio"/> | <input type="radio"/> | 1. | Do you have a current medical problem? | _____ |
| <input type="radio"/> | <input type="radio"/> | 2. | Have you been told you have a heart murmur? | _____ |
| <input type="radio"/> | <input type="radio"/> | 3. | Do you have any heart problems? What kind? | _____ |
| <input type="radio"/> | <input type="radio"/> | 4. | Do you have high or low High Blood Pressure blood pressure? | _____ |
| | | | <input type="radio"/> High Blood Pressure | |
| | | | <input type="radio"/> Low Blood Pressure | |
| | | | How is it controlled? | _____ |
| <input type="radio"/> | <input type="radio"/> | 5. | Have you had rheumatic fever? When? | _____ |
| <input type="radio"/> | <input type="radio"/> | 6. | Have you had pain in your chest or shortness of breath? | _____ |
| <input type="radio"/> | <input type="radio"/> | 7. | Do your ankles swell? | _____ |
| <input type="radio"/> | <input type="radio"/> | 8. | Has your physician ever told you that you are anemic? | _____ |
| <input type="radio"/> | <input type="radio"/> | 9. | Have you ever had a stroke? When? | _____ |
| <input type="radio"/> | <input type="radio"/> | 10. | Have you ever had epilepsy? | _____ |
| <input type="radio"/> | <input type="radio"/> | 11. | Do you have diabetes? Is it controlled? | _____ |
| <input type="radio"/> | <input type="radio"/> | 12. | Do you have fainting or dizzy spells? | _____ |
| <input type="radio"/> | <input type="radio"/> | 13. | Do you feel like your sense of balance has changed? | _____ |
| <input type="radio"/> | <input type="radio"/> | 14. | Do you have headaches? How often? Where? | _____ |
| <input type="radio"/> | <input type="radio"/> | 15. | Do you take Aspirin, Advil, Tylenol or another pain reliever? How often? | _____ |
| <input type="radio"/> | <input type="radio"/> | 16. | Have you been advised not to take any medication? What? | _____ |
| <input type="radio"/> | <input type="radio"/> | 17. | Do you have asthma or hay fever? How is it controlled? | _____ |
| <input type="radio"/> | <input type="radio"/> | 18. | Have you ever had tuberculosis? When? | _____ |
| <input type="radio"/> | <input type="radio"/> | 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: Gained weight
Weight: _____ Height: _____ 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?

- | | | | |
|-----------------------|--------------|-----------------------|------|
| <input type="radio"/> | Jaw | <input type="radio"/> | Ear |
| <input type="radio"/> | Face | <input type="radio"/> | Neck |
| <input type="radio"/> | Teeth | <input type="radio"/> | Head |
| <input type="radio"/> | 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?

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	_____	_____
Ringling 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

Other

Name: _____

Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Initial: _____

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 | 0 - Would never doze

1 - Slight chance

2 - Moderate chance of dozing

3 - High chance of dozing |
| _____ 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 | |

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 Sydenham Family Dental 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 Sydenham Family Dental 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 Sydenham Family Dental 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: _____