Personal information

(Please Print Clearly)

Surname: _____ Salutation (*circle*): Mrs. Miss Ms. Mr. Dr.

First Name: _____ Middle Name: _____

Preferred Given Name to be used at our Clinic: _____

Your Date of Birth (mm/dd/yyyy): _____

Home Address: _____ City: _____

Province: **Alberta** (or): _____ Postal Code: _____

Telephone: Home: _____ Business/Cell:_____

Email Address: _____

Contact in case of Emergency: ☐ None or Name: _____ Phone: _____

Relationship: : ☐ Spouse ☐ Other (specify): _____

Referred by: ☐ Spouse/Friend ☐ Dentist ☐ Website ☐ Flyer/Ad ☐ Other:_____

Family Doctor's Name: _____ Phone Number: _____

Family Dentist's Name: _____ Phone Number: _____

How would you like us to contact you for appointment confirmation? ☐ Telephone ☐ Email

Dental Insurance Information – Government Plans and/or Private Insurance Coverage

AISH/Alberta Works Card: _____ Alberta Health Care #: _____

NIHB ID#: _____ Band Name (*if applicable*): _____

Private Dental Insurance Company: _____ Group Number: _____

Subscriber's Name _____ Subscriber Birthdate (m/d/y) _____

Subscriber's Employer _____ Certificate or ID# _____

Secondary Insurance Information:

Private Dental Insurance Company: _____ Group Number: _____

Subscriber's Name _____ Subscriber Birthdate (m/d/y) _____

Subscriber's Employer _____ Certificate or ID# _____

I authorize release to my benefits plan administrator, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described, to the denturist. I understand and agree that in some cases, assignment of my insurance plan will only be accepted with a written pre-authorization and a credit card guarantee.

I further understand and agree that if I have provided an email address, this will only be used for purposes of my treatment at Oakridge Denture Centre; it will not be shared or distributed or used for commercial purposes.

Signature: _____ **Date:** _____

Medical Health History

1. Are you currently under the care of a physician? …… ☐ Yes ☐ No

   If yes, what for?

2. Please place an ***"X"*** into the appropriate box for the listed health issues.

   Indicate "**Yes**" if you previously had the condition even if you do not currently have that condition.

   Where applicable, please circle the correct type of condition or specify.

YES	NO		YES	NO	
☐	☐	Alcohol problems/Drug Dependency	☐	☐	Heart Attack/Heart Disease/Stroke
☐	☐	Environmental or Food Allergies	☐	☐	Pacemaker
☐	☐	Latex Allergy	☐	☐	Blood Pressure Issue: ***If yes***, *circle type:* ***High Low***
☐	☐	Asthma	☐	☐	Nervousness/Psychiatric condition
☐	☐	Chronic Obstructive Pulmonary Disease (***COPD***)	☐	☐	Alzheimer's Disease/Dementia
☐	☐	Tuberculosis	☐	☐	Depression
☐	☐	Hepatitis: ***If yes***, *circle type:* ***A B C***	☐	☐	Herpes Virus (cold sores)
☐	☐	Diabetes: ***If yes***, *circle type:* ***Type 1 Type 2***	☐	☐	Immune Deficiency
☐	☐	Thyroid Disease: ***If yes***, *circle type:* ***Hypo Hyper***	☐	☐	HIV / AIDS
☐	☐	Arthritis: ***If yes***, *circle type:* ***Osteo Rheumatoid***	☐	☐	Dizziness/ Fainting/ Epilepsy/ Seizures
☐	☐	Artificial Joint Replacement	☐	☐	Sleep Apnea
☐	☐	Cancer. ***If yes,*** *specify type***:**			
☐	☐	Other Condition(s). ***If yes***, *specify*:			

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Notes related to Medical Conditions

3. Are you taking Prescription Medications, Over the Counter Medications, or Herbal Remedies? ☐ Yes ☐ No
4. Have you recently lost or gained a significant amount of weight? …… ☐ Yes ☐ No
5. Do you smoke? …… ☐ Yes ☐ No

   If yes, for how long? …… _____ years
6. Women: Are you pregnant? …… ☐ Yes ☐ No

7. When was your last dental visit? ……			
8. Do you normally have an unpleasant odour/taste in your mouth? ……..	☐ Yes	☐ No	
9. Do you have any pain in your jaw joint? …….....	☐ Yes	☐ No	
10. Do you clench or grind your teeth?	☐ Yes	☐ No	
11. Do you have dental implants? …….....	☐ Yes	☐ No	
12. Have you ever had a serious accident or trauma/injury to your neck or jaws?	☐ Yes	☐ No	
If yes, specify:			
13. Do you have any sore spots or anomalies in your mouth? …….....	☐ Yes	☐ No	

Dental Health History

Please place an *"X"* into the appropriate box or provide your written response

Complete the following questions only if you have some or all of your natural teeth

14. Do you have any dental work ongoing or outstanding at this time? ……..……..……..	☐ Yes	☐ No	
15. Do you have any sensitive teeth? …..……..……	☐ Yes	☐ No	
16. How often do you brush your teeth? ……..…	☐ Daily	☐ Weekly	☐ Never
17. How often do you floss your teeth? ……	☐ Daily	☐ Weekly	☐ Never
18. How often do you see a Dental Hygienist? ……	☐ Yearly	☐ Bi-Yearly	☐ Never

Complete the following questions only if you have a denture or dentures

19. What type of denture(s) do you have? (complete or partial) ……..	**Upper**:	Complete: ☐	Partial: ☐
	Lower:	Complete: ☐	Partial: ☐
20. How old are your dentures? ..……....	Upper: _____ (years)	Lower: _____ (years)	
21. How many dentures have you had (if applicable)?	Upper: _____	Lower: _____	
22. Who provided you with your current denture(s)? ☐ Don't Remember ☐ Prefer not to say	**Upper**:		
	Lower:		
23. Do your gums get sores under your denture(s)? …….....	Upper ☐ Yes ☐ No	Lower ☐ Yes ☐ No	
24. Do you brush your gums under your denture(s)? ……..……	Upper ☐ Yes ☐ No	Lower ☐ Yes ☐ No	
25. Do you wear your denture(s) at night? ……..……	Upper ☐ Yes ☐ No	Lower ☐ Yes ☐ No	
26. Are you happy with the appearance of your denture(s)? ……	☐ Yes	☐ No	
27. Do you have problems eating any types of food? ……..……	☐ Yes	☐ No	
28. Do you use denture adhesives? ……	☐ Yes	☐ No	
29. Have the benefits of dental implants been discussed with you? ……..……	☐ Yes	☐ No	

"I the undersigned, hereby certify/affirm that all of the medical and dental information provided on this form to be true to the best of my knowledge and that I have not knowingly omitted any information."

Dated this ____ day of _____, 2019.

_____

Patient Signature

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Notes related to Responses on the Medical and Dental Histories

Question Number	Notes

This Medical and Dental History has been reviewed by myself and discussed with the patient:

Practitioner Signature:		Date: