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: _____

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

Relationship: _____

Email Address: _____

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

Family Doctor's Name: _____ Phone Number: _____

Family Dentist's Name: _____ Phone Number: _____

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

Dental Health History

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

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

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)? **Upper**:

☐ Don't Remember ☐ Prefer not to say **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 _____, 2021.

_____

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: