

Stuart Denture Clinic

Patient Information

Mr. Mrs. Ms. Miss

Date: _____

Name: _____ Gender: F or M

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Cell Phone: _____

If over 65, Alberta Health Care #: _____

Social Insurance #: _____

Occupation: _____

Referred By: _____

In case of Emergency, please contact: _____

Relationship: _____ Home Phone: _____ Cell: _____

Medical History

Are you in good health at the present time? _____

Are you under the care of a Physician? _____

Are you taking any medications? Please list _____

Do you have any allergies? Please list _____

Do you have or have had any of the following:

Diabetes _____ Heart Disease _____ High/Low Blood Pressure _____ Asthma _____

HIV _____ Tuberculosis _____ Thyroid Disorder _____ Epilepsy _____ Cancer _____

Arthritis _____ Digestive Disorder _____ Sexually Transmitted Disease _____

Stroke _____ Kidney Disease _____ Gastrointestinal Disorder _____ Hepatitis _____

Mental Disorder _____ Eating Disorder _____ Hearing Loss _____ Earaches _____

Frequent Headaches _____ Other _____

Do you Bruise easily or Bleed abnormally? _____

Have you Gained or Lost weight recently? _____ If yes, how much? _____

Do you have Frequent Neck, Shoulder or Back pain? _____

Ringing in ears? _____ Do you smoke? _____

Have you ever had any major injury or surgery to the face or Jaw? _____

Any pain/numbness in the head, neck or jaws? _____

Do you frequently have indigestion? _____

Are you Pregnant? _____

Do you grind your teeth? _____

Dentist: _____ Phone Number: _____

Physician: _____ Phone Number: _____

Denture History

Date of last Dental Visit _____ Reason for visit _____

Have you had radiographs taken within the last 2 years? _____

Do you have any ongoing dental procedures? _____ If yes, what? _____

Do you have: Complete Upper _____ Complete Lower _____

Partial Upper _____ Partial Lower _____

Implants _____

Age of current dentures: _____

Current dentures made by: _____

Are you happy with the appearance of your dentures? _____

Do you have problems eating any particular types of food? _____

Do your gums get sore under your dentures? _____

How often do you brush your natural teeth (if applicable)? _____

How often do you floss your natural teeth (if applicable)? _____

Do you brush your gums under your dentures? _____

Do your gums bleed when you brush or floss? _____

Do you wear you denture(s) at night? _____

Do you use adhesives? _____

Do you have any habitual conditions, mouth breather or chew on foreign objects?

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

Signature: _____

Dental Insurance

Policy Holder: _____

Date of Birth: _____

Employer: _____

Insurance Company: _____

ID/Certificate #: _____

Group/Policy #: _____

Do you have Dual Insurance? Yes or No

If yes,

Policy Holder: _____

Date of Birth : _____

Employer: _____

Insurance Company: _____

ID/Certificate #: _____

Group/Policy #: _____