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 #: _____