103-4917 Pemberton Road, Port Alberni, B.C. V9N1K2 (P)250-723-1811

Date ____________________

Mr. / Mrs. / Ms. / Miss
Name ____ Birthdate _______/_______/________

Address _______________________________________City ________________ Postal Code _________

Phone: Home___________________ Work __________________ Cell ____________________

Doctor _________________________ Dentist __________________________

Referred By ______________________________

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Medical History

1. Are you being treated for any medical condition at present? __ Yes __ No
   If so, please explain: ____
   ____

2. Have you had any serious illness / injury or surgery in the past 2 years? __ Yes __ No
   If so, please explain ____
   ____

3. Are you presently taking any prescription/nonprescription medications? __ Yes __ No
   If yes, please list ____
   ____

4. Do you have any allergies that you are aware of? __ Yes __ No
   If yes, please list ____

   Are you allergic to any of the following? __Latex __ Metals __ Plastics

5. Do any of these allergic conditions result in headache, swelling, shortness of breath, chest constriction, burning sensation in your mouth? __ Yes __ No
6. Do you smoke? __ Yes __ No
7. Have you tested positive for HIV? __ Yes __ No
8. Have you tested positive for Hepatitis A B C? __ Yes __ No

Do you have any of the following?

__ Alzheimer
__ Anemia
__ Arthritis
__ Epilepsy/Seizures
__ Fibromyalgia
__ Head / Neck Injury
__ Parkinson's disease
__ Radiation / Chemotherapy
__ Rheumatic fever

__ Blood transfusion
__ Cancer
__ Diabetes
__ Emphysema
__ Heart Disease
__ High/Low blood pressure
__ Lupus
__ Migraines
__ Stroke
__ Thrush
__ Thyroid Disorder
__ Tuberculosis
__ TMJ Disorder

Denture/Dental History

Do you chew well with your dentures? __ Yes __ No
Does food get under your dentures? __ Yes __ No
Do you wear your dentures at night? __ Yes __ No
Do you grind or clench your teeth? __ Yes __ No
Are your dentures loose? __ Yes __ No
Are your dentures comfortable? __ Yes __ No
Do you gag easily? __ Yes __ No
Are you satisfied with the look of your dentures? __ Yes __ No
How old are your current dentures? ____________
If you have any natural teeth remaining, when was your last visit with the dentist? ________________________

* *

Dental Insurance

Insurance Carrier ____

Group # _______________________ **ID #**_________________________ **Dep.**______________

Plan % A_________**% B**_______**% C** _________**%**

Insurance Carrier #2 ____

Group # _______________________ **ID #**______________________ **Dep.**______________

Plan% A________**% B**________**% C**_______**% Employer**______________________________

Subscribers Name: _____________________________ **D.O.B.**______________________

* *

We want you to understand the services we hope to provide to you, the cost involved, and what we do with the personal information we obtain about you. If you have any questions, please ask.

CONSENT FOR PERSONAL INFORMATION

I understand that to provide me with denture health care goods and services, the denturist will collect some personal information about me like, but not limited to, home address, telephone number, and medical history.

I understand that in accordance with this denturist's Privacy Policy, the collection and disclosure of my

personal information will be protected and remain within the scope of this denturist's practice. I understand and agree that the denturist may use my address and telephone number to communicate to me within the scope of practice and in relation to the provision of denture health care.

I understand how the privacy policy applies to me and I have been given a chance to ask any questions I have about the Privacy Policies and they have been answered to my satisfaction.

I, the undersigned, hereby certify the information given by me to be accurate, and I assume responsibility for all fees incurred.

Patient Signature: ____ Date: ________________________________

Date	Description	Fee	Patient	Plan

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

NOTES: _________________________
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SHADE: ________________________
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