



519B 5<sup>th</sup> Street, Courtenay B.C. V9N1K2 (P)250-897-1884 (F)250-897-1883

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

Epilepsy/Seizures

Parkinson's disease

Anemia

Fibromyalgia

Radiation / Chemotherapy

Arthritis

Head / Neck Injury

Rheumatic fever

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Thrush           |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Lupus                   | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Emphysema         | <input type="checkbox"/> Migraines               | <input type="checkbox"/> Tuberculosis     |
|  |  | <input type="checkbox"/> 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? \_\_\_\_\_

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**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. \_\_\_\_\_

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**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**

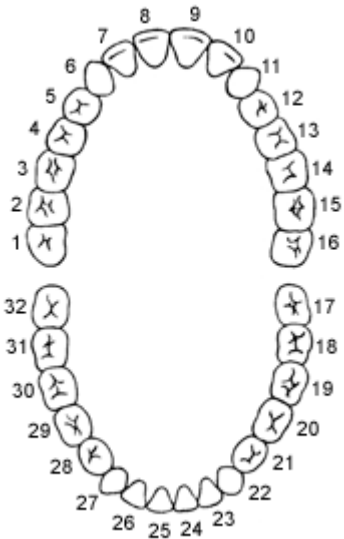
personal information will be protected and remain within the scope of this dentist's practice. I understand and agree that the dentist may use my address and telephone number to communicate to me within the scope of practice and in relation to the provision of denture health care.

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



NOTES: \_\_\_\_\_  
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SHADE: \_\_\_\_\_  
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