

Personal information

(Please Print Clearly)

| Surname: | Salutation (<i>circle</i>): Mrs. Miss Ms. Mr. Dr. | | | |
|---|---|--|--|--|
| First Name: | Middle Name: | | | |
| Name to be used at our Clinic: | _ Date of Birth (mm/dd/yyyy): | | | |
| Home Address: | City: | | | |
| Province: Alberta (or): | Postal Code: | | | |
| Telephone: Home: | Business/Cell: | | | |
| Your Email Address: | | | | |
| Contact in case None or Name: | Phone: | | | |
| of Emergency: Their Relationship to You: | | | | |
| 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 P | rivate Insurance Coverage | | | |
| Alberta Health Care #: | AISH/Alberta Works Card: | | | |
| NIHB ID#: Band Name & Number: | | | | |
| Private Primary Dental Insurance Information: | | | | |
| Insurance Company: | Certificate or ID#: | | | |
| Subscriber's Employer: | Group Number: | | | |
| Subscriber's Name: Subscriber Birthdate (m/d/y) | | | | |
| Private Secondary Dental Insurance Information: | | | | |
| Insurance Company: | Certificate or ID#: | | | |
| Subscriber's Employer: | Group Number: | | | |
| Subscriber's Name: | Subscriber Birthdate (m/d/y) | | | |
| 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 & Implant Centre; it will not be shared or distributed or used for commercial purposes. | | | | |
| Signature: | _ Date: | | | |

| Med | ical He | ealth History | | | | | |
|---|--------------------|---|----------|--------|---|--------|------|
| 1. A | re you | currently under the care of a physician? | | | <u></u> | Yes | ☐ No |
| | If yes, | what for? | | | | | |
| 2. P | lease p | lace an "X" into the appropriate box for the listed h | ealth is | sues. | | | • |
| Ir | ndicate | "Yes" if you previously had the condition even if yo | u do no | ot cur | rently have that condition. | | |
| W | /here a | applicable, <u>please circle the correct type</u> of condition | or spe | ecify. | | | |
| YES | NO | | YES | NO | | | |
| | | Alcohol problems/Drug Dependency | | | Heart Attack/Heart Disease/Stroke | | |
| | | Environmental or Food Allergies | | | Pacemaker | | |
| | | Latex Allergy | | | Blood Pressure Issue: <i>If yes, circle type: H</i> | ligh L | ow |
| | | Asthma | | П | Nervousness/Psychiatric condition | | |
| | | Chronic Obstructive Pulmonary Disease (<i>COPD</i>) | | | Alzheimer's Disease/Dementia | | |
| | | Tuberculosis | | | Depression | | |
| | | Honorities If use circle types A. P. C. | | | Hornos Virus (cold coros) | | |
| | | Hepatitis: If yes, circle type: A B C Diabetes: If yes, circle type: Type 1 Type 2 | | | Herpes Virus (cold sores) Immune Deficiency | | |
| | | Thyroid Disease: If yes, circle type: Hypo Hyper | H | | HIV / AIDS | | |
| | | , | | | , | | |
| | | Arthritis: <i>If yes, circle type: Osteo Rheumatoid</i> | | | Dizziness/ Fainting/ Epilepsy/ Seizures | | |
| | | Artificial Joint Replacement | | | Sleep Apnea | | |
| | | Cancer. <i>If yes,</i> specify type: | | | | | |
| | | | | | | | |
| | | Other Condition(s). <i>If yes, specify</i> : | | | | | |
| | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | |
| 011: | | | | | | | |
| | Use Or s relate | ny: ed to Medical Conditions | | | | | |
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| 3. Are you taking Prescription Medications, Over the Counter Medications, or Herbal Remedies? | | | | | | | |
| 4. Have you recently lost or gained a significant amount of weight? | | | | | | | |
| 5. Do you smoke? | | | | | | | |
| If yes, for how long? years | | | | | | | |
| | | | | | | v | |
| 6. Women: Are you pregnant? | | | | | | | |

| Dental Health History Please place an "X" into the appropriate box or provide your written response |
|---|
| 7. When was your last dental visit? DATE |
| 8. Do you normally have an unpleasant odour/taste in your mouth? |
| 9. Do you have any pain in your jaw joint? |
| 10. Do you clench or grind your teeth? |
| 11. Do you have dental implants? |
| 12. Have you ever had a serious accident or trauma/injury to your neck or jaws? |
| If yes , specify: |
| 13. Do you have any sore spots or anomalies in your mouth? |
| |
| 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? |
| 15. Do you have any sensitive teeth? |
| 16. How often do you brush your teeth? |
| 17. How often do you floss your teeth? |
| 18. How often do you see a Dental Hygienist? |
| |
| Complete the following questions only if you have a denture or dentures |
| 19. What type of denture(s) do you have? (complete or partial) |
| Lower: Complete: Partial: |
| 20. How old are your dentures? Upper: (years) Lower: (years) |
| 21. How many dentures have you had (if applicable)? |
| 22. Who provided you with your current denture(s)? Don't Remember Prefer not to say Lower: |
| |
| |
| 24. Do you brush your gums under your denture(s)? |
| 25. Do you wear your denture(s) at night? |
| 26. Are you happy with the appearance of your denture(s)? |
| 27. Do you have problems eating any types of food? |
| 28. Do you use denture adhesives? |
| 29. Have the benefits of dental implants been discussed with you? |

| "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 | , 2022. | | |
| Patient Signature | | | | |

| DENTURIST Use Only Notes related to Responses on the Medical and Dental Histories | | | | |
|---|-------|-------|--|--|
| Question Number | Notes | | | |
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| This Medical and Dental History has been reviewed by myself and discussed with the patient: | | | | |
| Practitioner Signature: | | Date: | | |