OAKRIDGE DENTURE & IMPLANT CENTRE

Suite 245, 125 Oakmoor Plaza SW
Calgary, Alberta T2V 4R9

Personal information

(Please Print Clearly)

Surname: _____ Salutation (*circle*): 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 Private Insurance Coverage

Alberta Health Care #: _____ AISH/Alberta Works Card: _____

NIHB ID#: _____ Band Name & Number: _____

Private Primary Dental Insurance Information:

Insurance Company: _____ Group Number: _____

Subscriber's Employer: _____ Certificate or ID#: _____

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 Centre; it will not be shared or distributed or used for commercial purposes.

Signature: _____ Date: _____

Medical Health History

1. Are you currently under the care of a physician? …… ☐ Yes ☐ No

   If yes, what for? _____

2. Please place an ***"X"*** into the appropriate box for the listed health issues.

   Indicate "**Yes**" if you previously had the condition even if you do not currently have that condition.

   Where applicable, please circle the correct type of condition or specify.

YES	NO		YES	NO	
☐	☐	Alcohol problems/Drug Dependency	☐	☐	Heart Attack/Heart Disease/Stroke
☐	☐	Environmental or Food Allergies	☐	☐	Pacemaker
☐	☐	Latex Allergy	☐	☐	Blood Pressure Issue: ***If yes****, circle type:* ***High Low***
☐	☐	Asthma	☐	☐	Nervousness/Psychiatric condition
☐	☐	Chronic Obstructive Pulmonary Disease (***COPD***)	☐	☐	Alzheimer's Disease/Dementia
☐	☐	Tuberculosis	☐	☐	Depression
☐	☐	Hepatitis: ***If yes****, circle type:* ***A B C***	☐	☐	Herpes Virus (cold sores)
☐	☐	Diabetes: ***If yes****, circle type:* ***Type 1 Type 2***	☐	☐	Immune Deficiency
☐	☐	Thyroid Disease: ***If yes****, circle type:* ***Hypo Hyper***	☐	☐	HIV / AIDS
☐	☐	Arthritis: ***If yes****, circle type:* ***Osteo Rheumatoid***	☐	☐	Dizziness/ Fainting/ Epilepsy/ Seizures
☐	☐	Artificial Joint Replacement	☐	☐	Sleep Apnea
☐	☐	Cancer. ***If yes,*** *specify type*:			
☐	☐	Other Condition(s). ***If yes****, specify*:			

Office Use Only:

Notes related to Medical Conditions

3. Are you taking Prescription Medications, Over the Counter Medications, or Herbal Remedies? …… ☐ Yes ☐ No
4. Have you recently lost or gained a significant amount of weight? …… ☐ Yes ☐ No
5. Do you smoke? …… ☐ Yes ☐ No

   If yes, for how long? _____ years
6. Women: Are you pregnant? …… ☐ Yes ☐ No

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?	☐ Yes	☐ No
9. Do you have any pain in your jaw joint?	☐ Yes	☐ No
10. Do you clench or grind your teeth?	☐ Yes	☐ No
11. Do you have dental implants?	☐ Yes	☐ No
12. Have you ever had a serious accident or trauma/injury to your neck or jaws?	☐ Yes	☐ No

If **yes**, specify:

13. Do you have any sore spots or anomalies in your mouth?	☐ Yes	☐ No

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?	☐ Yes	☐ No	
15. Do you have any sensitive teeth?	☐ Yes	☐ No	
16. How often do you brush your teeth?	☐ Daily	☐ Weekly	☐ Never
17. How often do you floss your teeth?	☐ Daily	☐ Weekly	☐ Never
18. How often do you see a Dental Hygienist?	☐ Yearly	☐ Bi-Yearly	☐ Never

Complete the following questions only if you have a denture or dentures

19. What type of denture(s) do you have? (complete or partial)	**Upper**:	Complete: ☐	Partial: ☐
	Lower:	Complete: ☐	Partial: ☐
20. How old are your dentures?	Upper: _____ (years)	Lower: _____ (years)	
21. How many dentures have you had (if applicable)?	Upper: _____	Lower: _____	

22. Who provided you with your current denture(s)? **Upper**:

☐ Don't Remember ☐ Prefer not to say **Lower**:

23. Do your gums get sores under your denture(s)?	Upper ☐ Yes ☐ No	Lower ☐ Yes ☐ No
24. Do you brush your gums under your denture(s)?	Upper ☐ Yes ☐ No	Lower ☐ Yes ☐ No
25. Do you wear your denture(s) at night?	Upper ☐ Yes ☐ No	Lower ☐ Yes ☐ No

26. Are you happy with the appearance of your denture(s)?	☐ Yes	☐ No
27. Do you have problems eating any types of food?	☐ Yes	☐ No
28. Do you use denture adhesives?	☐ Yes	☐ No
29. Have the benefits of dental implants been discussed with you?	☐ Yes	☐ No

"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 _____, 2024.

_____

Patient Signature

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