Blue Fern Denture Clinic

Welcome to our office
The following information is required to enable us to provide you with the best possible dental care.

Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ☐

Name: *Last* _____ *First* _____ *Initial* _____ Prefer to be called _____

Mailing Address: _____ **City:** _____ **Postal Code** _____

Home Phone: (____) _____ - _____ **Cell Phone**: (____) _____ - _____ **Other Phone**: (_____) _____ - _____

Age ____ **Birth Date**: _____/_____/_____. ☐**Male** ☐**Female** **Marital Status**: _____
Day Month Year

Patient Email _____

Family or Referring Dentist: _____ **Phone**: (_____) _____ - _____.

Family Physician: _____ **Phone:** (_____) _____ - _____.

In Case of Emergency, Notify: _____ **Relationship:** _____ **Phone:** (_____) _____ - _____.

Person Responsible for Account: ☐*Self* ☐*Spouse* ☐*Other*

If Spouse or Other is Responsible for Your Account, Please Complete Information Below:

Name: *Last* _____ *First* _____ *Initial* _____ *Relationship-* _____

Address: _____ **City:** _____ **Postal Code** _____

Home Phone: (____) _____ - _____ **Cell Phone**: (____) _____ - _____

Alberta Health Care Number _____

AISH/Social Services Number (If applicable) _____

Department of Veteran's Affair Number (if applicable) _____

First Nations/Inuit Health Number (if applicable) _____

Primary Insurance

Subscriber: _____ _____
Birth Date

Relationship: ☐ *Self* ☐ *Spouse* ☐ *Other:* _____

Place of Employment: _____

Insurance Company: _____

Policy/Plan #: _____ **Div./Sect. #:** _____

Subscriber I.D./Cert. #: _____

Secondary Insurance

Subscriber :_____ _____
Birth date

Relationship: ☐ *Self* ☐ *Spouse* ☐ *Other:* _____

Place of Employment: _____

Insurance Company: _____

Policy/Plan #: _____ **Div./Sect. #:** _____

Subscriber I.D./Cert. #: _____

Presently Do You Have:

- Complete Upper Denture	☐ Yes	☐ No	Age of Denture: _____	Made by: _____
- Complete Lower Denture	☐ Yes	☐ No	Age of Denture: _____	Made by: _____
- Partial Upper Denture	☐ Yes	☐ No	Age of Denture: _____	Made by: _____
- Partial Lower Denture	☐ Yes	☐ No	Age of Denture: _____	Made by: _____
- Dental Implants	☐ Yes	☐ No	Age of Implants: _____	Made by: _____

HOW DID YOU FIND OUT ABOUT OUR CLINIC?

Web Site_____ Family Dentist _____ Friend _____ Other_____

cont on page 2...

Medical / Dental History

Are you in good health at the present time? ☐ Yes ☐ No

Are you under the care of a physician at the present time? ☐ Yes ☐ No

Are you on any medication at the present time? ☐ Yes ☐ No

If yes, please list your medications or attach list to back of sheet: _____

_____

Do you have any allergies? ☐ Yes ☐ No

If yes, please list what you are allergic to: _____

Do you have or have had any of the following conditions (please check only those that apply):

☐Allergies	☐High Blood Pressure	☐Low Blood Pressure
☐Anemia	☐Heart Disease	☐Arthritis
☐Kidney Disorder	☐Bleeding Disorder	☐Breathing Disorder
☐Sexually Transmitted Disease	☐Chronic Headaches	☐Sinusitis
☐Diabetes	☐Stroke	☐Epilepsy
☐Tuberculosis	☐ Facial Muscle Pain	☐Thyroid Disease
☐Gastrointestinal Disorder	☐Cancer	☐Dry Mouth
☐Mental or Nervous Disorder	☐Hepatitis _____	☐Other: _____

Do you smoke or use chewing tobacco? If yes, Per Day: ____ Per Years: _____ ☐ Yes ☐ No

Do you have pain when you chew? ☐ Yes ☐ No

Do you snore or have sleep issues? ☐ Yes ☐ No

Have you had a recent change in your weight? How much? ____☐Lost or ☐Gain ☐ Yes ☐ No

Do any of your teeth ache? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you have any unusual oral habits? (Nail biting, etc.) ☐ Yes ☐ No

When was your last dental visit?_____ When did you last have dental x-rays? _____

OTHER NECESSARY INFORMATION:_____

_____

GENERAL CONSENT STATEMENT

I certify that I have read, understood and accurately completed the personal, medical, and dental histories, to the best of my knowledge, and not knowingly omitted any information. I authorize the denturist to perform necessary diagnostic procedures and treatment, as required, to achieve the proper level of dental care. I understand that I am financially responsible to the denturist for any dental services provided even if my insurance coverage may not be all inclusive. Please be advised all overdue accounts will be subject to a 2% monthly finance charge.

Patient Signature:_____ **Date:**_____

Medical history Updates

Patient Signature:_____ **Date:**_____

Patient Signature:_____ **Date:**_____