

Jetport Denture Center Patient History Form

Patient Name: _____ Date of Birth: _____

Address: _____ City/Town: _____ Zip: _____

Phone (Home): _____ Phone (Cell): _____

Email: _____ Male/ Female

Emergency Contact Person: _____ Phone: _____

Primary Care Physician's Name: _____

Dental Insurance: Yes/ No (If yes, name of insurance): _____

Does your medical history include any of the following:

- | | | |
|--|-----|----|
| 1. Are you presently taking Coumadin, Plavix, aspirin or any other blood thinner? | Yes | No |
| 2. Do you require premedication? | Yes | No |
| 3. Rheumatic fever or rheumatic heart disease? | Yes | No |
| 4. Heart Surgery, heart disease, heart attack, high blood pressure or stroke? | Yes | No |
| 5. Artificial heart valve or pulmonary shunt? | Yes | No |
| 6. Rheumatoid arthritis? | Yes | No |
| 7. Cancer radiation treatment or chemotherapy? | Yes | No |
| 8. Peanut or pine nut allergy? | Yes | No |
| 9. Blood disorders or anemia? | Yes | No |
| 10. Abnormal bleeding, prolonged healing or bruising easily? | Yes | No |
| 11. Asthma or hay fever? | Yes | No |
| 12. Fainting spells, seizures or epilepsy? | Yes | No |
| 13. Hepatitis, jaundice or liver diseases? | Yes | No |
| 14. Kidney trouble? | Yes | No |
| 15. Diabetes? | Yes | No |
| 16. HIV/AIDS? | Yes | No |
| 17. Artificial joints? | Yes | No |
| 18. MRSA (Methicillin Resistant Staphylococcus Aureus) | Yes | No |
| 19. Sleep Apnea? | Yes | No |
| 20. Nervous disorders? | Yes | No |
| 21. Headaches? | Yes | No |
| 22. Sensitivity or allergic reaction to latex? | | |
| 23. Sensitivity or allergic reaction(s) to any medicines, i.e. penicillin, codeine, iodine, dyes, sulfur drugs, etc.?
(Please List) _____ | | |
| _____ | | |
| _____ | | |

24. Do you have a condition(s) not listed? Yes No
(Please specify): _____

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25. Are you taking any of the following? (please circle if yes): Fosamax Didronel Didrocal Co Etidronate Gen Etidronate Boniva Actonel Skelid Bonefos Clasteon Ostac Aredia Zometa Aclasta
Or any other bisphosphonates for osteoporosis

26. Please list any medication you are presently taking (we can photocopy your list if needed):

- | | | |
|---|-----|----|
| 27. Do you smoke or chew tobacco? | Yes | No |
| 28. Are you on any special diet? | Yes | No |
| 29. Are you experiencing any changes in weight? | Yes | No |
| 30. Do you snore? | Yes | No |
| 31. If you have all or some of your natural teeth, are your teeth sensitive to (circle if applicable):
Cold Sweets Biting Pressure Other (please specify): _____ | | |
| 32. Do you want to keep your remaining teeth? | Yes | No |
| 33. Do you grind or clench your teeth? | Yes | No |
| 34. Does your jaw crack, pop or grate? | Yes | No |
| 35. Do you have lumps, sores, or discomfort in your mouth? | Yes | No |
| 36. Do you have a specific dental problem?
If yes, please explain: _____ | Yes | No |
| 37. Do you get routine dental exams? | Yes | No |
| 38. Have you had any injuries or surgeries to your mouth? | Yes | No |
| 39. Do you presently wear dentures?
If yes, please specify: Full Dentures Top/Bottom Partial Dentures Top/Bottom | | |
| 40. How long have you been a denture wearer? _____ | | |
| 41. How old are your current dentures? _____ Have they been relined? Yes/No | | |

How did you hear about us? _____

I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE. Initial _____

Acknowledge of receipt of Notice of Privacy Practices

I have completed this form to the best of my ability and have read the HIPAA NOTICE OF PRIVACY PRACTICES (version 1). I understand that I can request a copy of this notice to take with me upon my request.

Printed Name

Date

Jetport Denture Center
980 Forest Ave
Portland, ME 04103

Surveillance Notice

I have been informed that, for the protection of the patients and the staff, this office Jetport Denture Center at 980 Forest Avenue, Portland ME is under continuous audio and video surveillance.

I agree to treatment at this office with the above stated knowledge.

Patient Signature: _____

Patient Contractual Agreement

Upon entering into treatment at this practice, I the patient, understand that the services being provided to me are for denture therapy and I am not just purchasing a denture or dentures. I understand that my treatment involves not only the appliances themselves and professional expertise, but also my active participation in my own treatment. It is my understanding that compliance with the patient education I am provided, return visits and patience will be required for successful treatment. I am aware that should I choose to unduly delay or abandon my treatment, at minimum, the cost of the initial deposit of my treatment will be retained for expenses and professional time.

Patient Signature: _____

Date: _____