

ALBERTA DENTURES – NEW PATIENT INTAKE FORM

1. Full Name: _____ Date of birth: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Mobile Phone: _____

Email: _____

2. Emergency contact Full Name: _____

Phone: _____ Email: _____

3. Do you have dental insurance? Yes No

Name of the insurance: _____

Plan number: _____ ID number: _____

4. How did you hear about us?

Internet Social Media Friend Facebook Dentist Referral Other: _____

5. Do you have a family physician? Yes No Name: _____

6. Do you have a dentist? Yes No

Contact number: _____ Name: _____

7. Are you being treated for any medical conditions at present or within the past 5 years? Yes No

8. Have you been injured or hospitalized in the last 2 years? Yes No

9. Are you presently taking any prescription/non-prescription medications? Yes No

10. Do you experience dry mouth with or without medication? Yes No

11. Which of the medical conditions apply to your family history?

Diabetes Heart disease Cancer Osteoporosis None

12. Have you ever had head, facial, jaw or neck trauma? Yes No

13. Do any of the following conditions apply to you?

<input type="checkbox"/> Facial muscle tenderness	<input type="checkbox"/> Earaches	<input type="checkbox"/> Burning sensation on your lips or tongue
<input type="checkbox"/> Joint clicking, popping or locking	<input type="checkbox"/> TMJ (Jaw) pain	<input type="checkbox"/> Gasp or stop breathing in your sleep
<input type="checkbox"/> Migraines or headaches	<input type="checkbox"/> Snoring	<input type="checkbox"/> Bleed excessively from a cut
<input type="checkbox"/> Neck or shoulder pain	<input type="checkbox"/> Hearing issues	<input type="checkbox"/> Lumps or sores in your mouth
<input type="checkbox"/> Grind your teeth	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Sore or tender gums <input type="checkbox"/> Other

14. Weight/appetite change: Yes No

15. Special diet: Yes No

16. Are you allergic to any of the following? Acrylic Latex Metal None

Please specify any other allergies: _____

17. Radiation/Chemo: Yes No

18. Hearing issues: Yes No

19. Memory issues: Yes No

20. Do you smoke: Yes No

21. Do you have any of the following?

- | | | | |
|------------------------------------|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Sexually Transmitted Infection (STI) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Mouth Cancer | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Thrush | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> HIV or AIDS Stroke T |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Hyper/Hypoglycemia |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> TMJ Disorder | <input type="checkbox"/> Other |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Hepatitis A/B/C | |

22. Is there anything the dentist should know about your health? _____

23. Do you have a full denture? Upper Lower Both None

24. Do you have partial dentures? Upper Lower Both None

25. How many dentures have you had? _____ 26. Do you have dental implants? Yes No

27. Remaining natural teeth? Yes No 28. Do you grind or clench your teeth? Yes No

29. When was your last visit to your dentist? _____ 30. Need dental work? Yes No

Denture Experience

31. Chew well: Yes No 32. Food under denture: Yes No 33. Loose: Yes No

34. Comfortable: Yes No 35. Wear at night: Yes No 36. Gag reflex: Yes No

37. Digestive issues: Yes No 38. Are you happy with your current dentures?: Yes No

39. Who made your current dentures? _____

40. What are your concerns with your current dentures? _____

Consent

- I certify that the medical and dental information I provided is accurate to the best of my knowledge, and I have not knowingly omitted any information.
- I consent to have my dentist or physician contacted if additional dental/medical information is required for my dental care.
- I consent to have treatment by my dentist.
- I assume responsibility for all fees incurred. All fees not covered by my insurance company is my responsibility.

Name of person filling out this form _____

Signature _____

Date _____