Blue Fern
DENTURE CLINIC

Name: Last_____First_____Prefer to be called_____

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

Home Phone:_____ **Cell:**_____**Patient Email**_____

Age_____ **Date of Birth** _____/_____/_____ ❑**Male** ❑**Female**
Day Month Year

Alberta Health Care Number _____

AISH/ Social Services/ NIHB Number (if applicable)_____

In Case of Emergency, Notify:_____Phone:_____Relationship_____

Primary Insurance	**Secondary Insurance**
Subscriber: _____	**Subscriber:**_____
Birth Date:_____	**Birth Date:**_____
Relationship: ❑ *Self* ❑ *Spouse*	**Relationship:** ❑ *Self* ❑ *Spouse*
Insurance Company: _____	**Insurance Company:**_____
Policy/Plan #: _____	**Policy/Plan #**: _____
Subscriber I.D./Cert. #: _____	**Subscriber I.D./Cert. #:**_____

Medical History

Do you have any allergies? ❑ Yes ❑ No
If yes, please list what you are allergic to: _____
Known Medical Issues:_____
_____

HOW DID YOU FIND OUT ABOUT OUR CLINIC?

Web Site ❑ Family Dentist ❑ Friend ❑ Other ❑

Dental History

Do you smoke or use chewing tobacco? ❑ 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? ❑ 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
Do you have tension headaches? ❑ Yes ❑ No
When was your last dental visit?_____When did you last have dental x-rays?_____
Family Dentist_____

Presently Do You Have:

Complete Denture Upper ❑ Lower ❑ Age of Denture_____Made By:_____
Partial Denture Upper ❑ Lower ❑ Age of Denture_____Made By:_____
Dental Implants Upper ❑ Lower ❑

Are you happy with the appearance of your teeth? ❑ Yes ❑ No
If no, what would you like to change? _____
_____

OTHER INFORMATION OF NOTE:_____

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.

Patient Signature:_____**Date:**_____

Medical history Updates

Patient Signature:_____ **Date:**_____
Patient Signature:_____ **Date:**_____