Westshore Denture Clinic

How did you hear about us? Walk-in___ Referral____ Phone Book___

Mr./Mrs./Ms._____ Address:_____

Occupation:_____ City:_____ Postal Code:_____

Email Address:_____ Tel: (H)_____(C)_____

Birthdate: Month_____Day_____ Year_____ Referred by:_____

Physician:_____ Insurance Coverage: Yes_____ No_____

Dentist:_____

Denture/Dental History:

Do you chew well with your dentures? Yes___ No___ Do you gag easily? Yes___No___

Do you wear your dentures at night? Yes___ No___ Do you chew gum?Yes___No___

Are your dentures loose? Yes___ No___ If yes, do you mean both___or just one___?

Do you grind/clench your teeth? Yes___ No___ Do you have tooth pain? Yes___No___

Do you have jaw joint pain? Yes___No___

Do you have burning pain in any areas in your mouth? Yes___ No___

If you already have dentures, were they made by a Denturist___ or Dentist____?

How long have you been wearing dentures?_____

How many dentures have you had? _____ Does food get under your dentures? Yes___No___

Age of Dentures: 0-4 yrs_____ 5-9 yrs.____10+ yrs.____ Are your dentures comfortable? Yes___No___

If you have any natural teeth remaining, when was your last visit with a dentist?_____

Do you need teeth extracted? Yes___ No___

Please list the concerns you have with your present dentures:_____

_____

What is on your wish list regarding your smile?_____

_____

Please indicate the types of changes you would like to see with your new dentures: Tooth size___

Shape___ Color___ Bite Position___ Lip Support___ No changes__

Medical History

Are you being treated for any medical condition at present or within the past 5 years Yes__No__

Are you presently taking any prescription or non prescription medication? Yes__No__

If yes, does your prescription medication cause dry mouth? Yes__No__

Do you have any allergies?_____

Are you allergic to: Latex gloves___ Metals___ Plastics___

Have any of these allergic conditions resulted in headache, swelling, shortness of breath, chest constriction or a burning sensation in your mouth? Yes__ No__

Is there a family history of diabetes, heart disease, cancer or osteoporosis? Yes__ No__

Do you bleed excessively from a cut or bruise easily? Yes__ No__

Has your weight, appetite or energy level changed dramatically recently? Yes__ No__

Do you smoke? Yes__ No__

Have you tested HIV positive? Yes__ No__

Have you tested positive for Hepatitis A, B or C? Yes__ No__

Do you wish to speak privately to the Denturist about any medical condition? Yes__ No__

Do you have any of the following:

Alzheimers____ Thyroid disorder___ Radiation/Chemotherapy___ Anemia___

Arthritis___ Head/Neck Injury___ Rheumatic Fever___ Stroke___ Cancer___

Blood Transfusion___ High Blood pressure___ Low Blood pressure___ Hodgkins Disease___

TMJ Disorder___ Diabetes___ Emphysema___ Hypo/Hyperglycemia___

Tuberculosis___ Fibromyalgia___ Parkinsons's Disease___ STD's ___

Migraines___

Please be advised that every effort will be made to satisfy all functional and esthetic patient demands however, due to the nature of dental appliances and the limitations of the oral environment cash refunds are not possible under any circumstances.

I, the undersigned, hereby certify the information given to me to be accurate, and I assume responsibility for all fees incurred.

Patient Signature:_____ Date:_____