ADDITIONAL REMARKS

GENERAL INFORMATION AND MEDICAL HISTORY

The information contained herein is considered confidential and is for our records only.

PLEASE WRITE OR PRINT CLEARLY

Date .....

PERSONAL HISTORY

Name: (Miss/Ms/Mrs/Mr/Dr) .....

Phone No. ..... Cell No. ..... E-mail Address .....

Address ..... City ..... Postal Code .....

Date of Birth ..... Employer ..... Position/Occupation .....

Business Address ..... BusinessPhone No. .....

Name of Spouse ..... Employer ..... Occupation .....

Person Financially Responsible ..... Address .....

Name of Dental Plan ..... Birthdate of Insurance Holder .....

Group No ..... I.D. or Social Insurance No. ..... Dependent No. .....

Percentage Cover Basic ..... Prosthetic ..... Crown and Bridge ..... Orthodontic .....

Referred By .....

Name of Your Dentist ..... Phone No. .....

In case of accident or emergency, whom should we contact? .....

What do you feel is your main dental problem? .....

MEDICAL HISTORY

Physician's Name ..... Phone No. .....

Address ..... Date of Last Check-up .....

Medical Specialist ..... Phone No. .....

PLEASE CIRCLE THE ANSWER THAT APPLIES (Y = yes; N = no)

Are you presently receiving treatment or supervision from your physician?	Y	N
Are you taking any pills or medication?	Y	N
Have you had any serious illness or injury?	Y	N
Have you ever been hospitalized?	Y	N
Has your general health changed in the past year?	Y	N
Have you had a change in your weight in the past year?	Y	N
Do you wear contact lenses?	Y	N
Do you consume alcoholic drinks, and if so, how much and how often?	Y	N
Are you thirsty much of the time?	Y	N
Do you regard yourself as having a nervous disposition?	Y	N
Have you ever had a nervous breakdown?	Y	N
Have you ever been treated by a psychiatrist?	Y	N
Do you eat an unusual diet? (e.g. - vegetarian, weight loss)	Y	N
Are you a smoker, and if so, how much do you smoke per day?	Y	N

MEDICAL HISTORY (continued)

Have you experienced any reaction to the following?

Aspirin	Y	N	Penicillin	Y	N
Dental anesthetic (as Novocaine)	Y	N	Tetracylines	Y	N
Sleeping pills (barbiturates)	Y	N	Other drugs	Y	N
Sulpha drugs	Y	N	Metals	Y	N
Codeine	Y	N	Foods	Y	N

Other substances .....

Have you ever had (when):

Hepatitis (liver disease)	Y	N	Kidney disease	Y	N
Jaundice (yellow skin and eyes)	Y	N	Thyroid or parathyroid trouble	Y	N
Painful or swollen joints	Y	N	Tumor or growth	Y	N
Rheumatic fever	Y	N	Radiation treatments	Y	N
Scarlet fever	Y	N	A stroke	Y	N
Unexplained fever	Y	N	Epilepsy	Y	N
Ulcers	Y	N	Facial pain	Y	N
Anemia or any abnormal blood counts	Y	N	Fits or convulsions	Y	N
Bleeding or bruising problems	Y	N	Frequent headaches	Y	N
Shortness of breath on mild exertion	Y	N	Numbness or tingling	Y	N
Chest pains on exertion	Y	N	Sinus trouble	Y	N
Glaucoma (eye disease)	Y	N	Tendency to faint	Y	N
Heart attack or heart trouble	Y	N	Asthma	Y	N
Heart murmur	Y	N	Emphysema	Y	N
High blood pressure	Y	N	Persistent cough	Y	N
Arthritis	Y	N	Delicate skin	Y	N
Diabetes (sugar in blood)	Y	N	Hives, skin rash, hay fever	Y	N

DENTAL HISTORY

When was your last visit to a dentist? .....

How frequently do you normally visit a dentist? 6 months ..... 1 year ..... infrequently .....

Where and when were the last dental x-rays made of your mouth? .....

Do your teeth decay easily?	Y	N
Do you have sensitive teeth?	Y	N
Have you ever had trouble with your gums?	Y	N
Does any member of your family wear dentures?	Y	N
Do you grind your teeth?	Y	N
Do you have difficulty opening your mouth?	Y	N
Do you experience neck, shoulder, arm or headaches?	Y	N
Do you have any other dental difficulties?	Y	N

DENTURE WEARERS

How many dentures have been made for you? .....

Upper: Complete denture ..... Removable partial denture .....

Lower: Complete denture ..... Removable partial denture .....

How many years have you worn dentures? .....

How many years have you worn your present dentures? .....

Do you wear your dentures at night? .....

Were your natural teeth removed as a result of:

Tooth decay? .....

Gum problems? .....

Is your mouth usually dry? .....

Present dentures were made By .....

When .....

Why .....

Do you have a particular problem with your dentures? .....

Do you have problems eating any foods (texture/content)? .....

Do you have a tendency to gag when wearing dentures? .....

Are you satisfied with the appearance of the dentures that you are wearing? .....

Is there anything else we should know concerning your health?	Y	N
Are you interested in knowing more about dental implants?	Y	N

I BELIEVE THE INFORMATION ON THIS FORM TO BE CORRECT AND TO PROVIDE A COMPLETE SUMMARY OF MY PAST OR PRESENT MEDICAL AND DENTAL STATUS.

Signature ..... DATE .....