Patient Name: ____________________________ **Date of Birth:** _________________

Medical History

1. Family Doctor _________________________________
2. Are you being treated for any medical or dental condition at present or within the past 5 years, please explain? □ yes □ no ____
3. Do you have or have you had any of the following:

□ Alzheimers/Dementia	□ Chemotherapy	□ Head or Neck Injury	□ Osteoporosis
□ Asthma	□ Radiation Treatment	□ High or low blood pressure	□ TMJ disorder
□ Anemia	□ Cholesterol	□ Heart Condition	□ Rheumatic Fever
□ Arthritis	□ COPD	□ Kidney problems	□ Sinus problems
□ Blood disorder	□ Diabetes (Type I or II)	□ Liver problems	□ Tuberculosis
□ Cancer	□ Epilepsy	□ MRSA	□ Thyroid problems

4. Are you presently taking any prescription / non-prescription medications? Please list or bring a copy to your appointment ____
5. Do you bleed excessively from a cut or bruise easily? □ yes □ no
6. Have you had significant weight loss? □ yes □ no
7. Do you smoke? □ yes □ no
8. Do you have Hepatitis A, B, or C, HIV or Aids? (Please circle) □ yes □ no
9. Do you have any allergies that you are aware of? _________________________ □ yes □ no
10. Are you allergic to any of the following: □ Latex gloves □ Metals □ Plastics □ yes □ no

Dental History

Do you chew well with your dentures? □ yes □ no

Are your dentures comfortable? □ yes □ no

Do you wear your dentures at night? □ yes □ no

My □ upper and/or □ lower dentures is loose.

Food gets under my □ upper and/or □ lower denture.

Do you use store bought adhesives or liners? □ yes □ no

Do you grind or clench your teeth? □ yes □ no

Do you have frequent gum pain or gum ulcers? □ yes □ no

I have digestive problems. □ yes □ no

Do you gag easily? □ yes □ no

Do you chew mints or gum? □ yes □ no

Approximate age of present dentures?

____0-4 ____5-9 ____10+ years

Approx. how many years have you been wearing dentures?

____

Approximate date or year dentures were made _________

How many dentures have you had? ___________________

Were your present dentures made by a denturist or dentist?

____

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

____

Please indicate the types of changes you would like to see with your new dentures: □ tooth size □ shape □ color □ fit □ function □ bite position □ lip support □ no changes Other: ____

The undersigned, hereby certify the information given by me to be accurate, and I assume responsibility for all fees incurred. All fees not covered by my insurance company will be my responsibility.

Patient signature: ____________________________________ Date: ____________________________

Email Address: ______________________________________