SUNSHINE COAST
DENTURE CLINIC

PATIENT INFORMATION FORM

Last name:	First name:	Birth date:	
Address:	City:	Postal Code:	
Home Phone no:	Cell phone no:	Email:	
Family member (optional)	Phone:	Email:	
Physician:	Dentist:	Personal Health Number (if applicable)	
Referred by:			

PATIENT INFORMATION FORM

Do you have dental insurance?	☐ Yes ☐ No If yes please provide your insurance details	
Carrier Name:	Certificate #	
Group #	Policy #	Member ID #

MEDICAL HISTORY FORM

1. Are you being treated for any medical condition at present or within the past 5 years? If yes, please explain:		
2. Please list any prescription/ nonprescription medications you are currently using or have recently used:		
3. Do you have any allergies causing anaphylactic reactions? Please list		
4. Are you allergic to the following: ☐ Latex Glove ☐Metals ☐ Acrylic		
5. Do you bleed excessively from ac cut or do you bruise easily?		☐ Yes ☐ NO
6. Has you weight changed dramatically recently?		☐ Yes ☐ NO
7. Do you smoke?		☐ Yes ☐ NO
8. Are you HIV positive or do you have AIDS?		☐ Yes ☐ NO
9. Have you tested positive for hepatitis A, B or C? (indicated which)		☐ Yes ☐ NO
10. Do you wish to speak privately with the denturist about any medical condition?		☐ Yes ☐ NO
11. Indicate bellow if you have history of any of the following		☐ Yes ☐ NO
☐ Alzheimer's	☐ Thyroid Disorder	☐ Radiation/ Chemotherapy
☐ Anemia	☐ Head/ Neck Injury	☐ Rheumatic Fever
☐ Arthritis	☐ Heart Disease	☐ Stroke
☐ Blood Transfusion	☐ High / Low Blood Pressure	☐ Thrush
☐ Cancer	☐ Hypo/ Hyperglycemia	☐ TMJ Disorder
☐ Emphysema	☐ Lupus	☐ Sexually Transmitted Diseases
☐ Epilepsy/ Seizures	☐ Migraines	☐ Tuberculosis
☐ Fibromyalgia	☐ Parkinson's Disease	☐ Drug Addiction
☐ Diabetes	☐ Hodgkins's Disease	☐

CURRENT DENTURES

What do you have for dentures?	
Upper: ☐ Complete ☐ Partial ☐ Dental Implants	**Lower:** ☐ Complete ☐ Partial ☐ Dental Implants
Approximately how old are your dentures?	
Who made your dentures?	
Please list any concerns you have with your dentures.	

NEW DENTURES

What kind of dentures are you looking for?
Do you still need extractions?
When was your last dental visit?
Do you have any outstanding dental treatment that needs to be done?

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CONSENT

I _____, hereby certify that the information provided is accurate. I consent to open communication between my denturist and dentist during the completion of my proposed treatment plan. I authorize the direct payment of my insurance benefits to the physician. I acknowledge my financial responsibility for any outstanding balance. Furthermore, I authorize Sunshine Coast Denture Clinic to release any information necessary to process my claims.

Patient Signature	Date

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