Strong Denture & Snoring

Denture & Oral Sleep Appliance Clinic

Patrick J. Strong, Denturist

Patient Information:

Patient Name: ______________________________

Address: ______________________________ City: ______________________

Postal Code: ______________ Home Phone #: ____________________

Cell #: ____________________ Work #: ____________________

Date of Birth: Day: __________ Month: __________ Year: __________

Employer: ______________________ or Retired: ______________________

Insurance Information: YES or NO

Dental Insurance Company: ___________________________

Group / Policy #: __________________ ID #: ______________________

Policy Holder Name: ____________________

Date of Birth: Day: __________ Month: __________ Year: __________

Relationship to Patient: Self: __________ Spouse: __________ Common Law: __________

Co-Insurance Information: YES or NO

Dental Insurance Company: ___________________________

Group / Policy #: __________________ ID #: ______________________

Policy Holder Name: ____________________

Date of Birth: Day: __________ Month: __________ Year: __________

Relationship to Patient: Self: __________ Spouse: __________ Common Law: __________

Health Information:

Family Doctor: ______________________________ Phone #: ______________________________

Family Dentist: ______________________________ Phone #: ______________________________

Are you presently under Medical Treatment: YES or NO

Are you taking any medications, and if so, please list below or provide a copy of list:

Have you ever been treated for ANY of the following:
(Please answer every question with a Yes or No)

Diabetes:	Respiratory Disease (Asthma):
Epilepsy:	Allergies:
Hepatitis:	High Blood Pressure:
HIV:	Contagious Disease:
Heart Problems:	Stroke:
Rheumatic Fever:	Other:

Additional Information: (Please answer every question with a Yes or No)

Have you gained or lost weight recently: (If so, how much?) ____________________

Do you have pain and/or clicking in your jaw? ____________________

Ringing in your ears? ____________________

Do you suffer from frequent headaches? ____________________

Do you have sensitive or painful natural teeth? ____________________

Do your gums feel tender or sore? ____________________

Any lumps or sore spots in your mouth? ____________________

Existing Denture Information:

How long have you been wearing dentures: ___________ Years

How many sets have you had? ___________

Existing Dentures:

Upper: Complete ______________ or Partial ______________ When made? ______________

Lower: Complete ______________ or Partial ______________ When made? ______________

Have your dentures been relined or rebase before? ______________ If so, when? ______________

What is the main problem you are having with your dentures?

How did you hear about our clinic?

- Yellow Pages
- Street Sign
- Biz X Magazine
- Website (online)
- Family (if so, name) ____
- Friend (if so, name) ____
- Dentist (if so, name) ____
- Walk In

Do you have an e-mail address? If so, please provide:____

Patient's Name: ____

Patient's Signature: ____ Date: ________________________