SIMPLY DENTURES

Tony Yu, Registered Denturist

LANGLEY
#102F-20995 88 Avenue
Langley, BC
T. 778-298-1333

ABBOTSFORD
650 - 2151 McCallum Road
Abbotsford, BC
T. 604-853-1694

info@simplydentures.ca

Medical History:

ALL INFORMATION IS CONFIDENTIAL

Name: _____
Prefix (Ms/Mrs/Mr) First Last

Address: _____
Street City Postal Code

Home Phone (_____)_____ Cell Phone: (_____) _____

Date of Birth _____ Email Address: _____
M D Y

Dentist's Name:_____ Office Name: _____

1. Are you presently under the care of a physician? ☐ YES ☐ NO
   If so, please explain _____
2. Have you ever had a serious illness? ☐ YES ☐ NO
   If so, please explain _____
3. Do you use any prescription or non-prescription medicine regularly? ☐ YES ☐ NO
   If so, please explain _____
4. Do you have any allergies?
   Are you allergic to the following:
   ☐ Latex ☐ Other _____
   ☐ Plastic _____
   ☐ Metal
5. Do any of these allergic reactions result in headache, shortness of breath, chest constriction, nausea or asthma-like conditions? Please specify _____ ☐ YES ☐ NO
6. Have you had any adverse reactions to any drugs or medications? ☐ YES ☐ NO
   Please list _____
7. Do you have or have you ever had any of the following:

☐ heart attack or other heart condition	☐ hepatitis A, B or C	☐ HIV/AIDS	☐ stroke	☐ lung disease
☐ blood disorders	☐ drug addiction	☐ liver/kidney disease	☐ lupus	
☐ joint replacement (hip, knees etc)	☐ Immune deficiency	☐ arthritis or rheumatism	☐ tuberculosis	
☐ organ transplant	☐ STD/STI/herpes	☐ hyper/hypoglycemia	☐ diabetes	
☐ high/low blood pressure	☐ cancer	☐ epilepsy or seizures	☐ head/neck/face/jaw injury	

8. Have you ever had radiation treatment or chemotherapy? ☐ YES ☐ NO
9. Do you bleed easily? ☐ YES ☐ NO
10. Do you have frequent earaches, ear/throat infections or any hearing difficulties? ☐ YES ☐ NO
11. Do you have any disease, problem or condition that you think the doctor/denturist should know about? ☐ YES ☐ NO

CERTIFICATION AND CONSENT:

I, the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I consent to my dentist, previous denturist or physician being contacted if necessary, as further dental/medical information may be required for my dental care. I, the undersigned, hereby consent to the performing of the preventive dental procedures. I, the undersigned, am aware that the whole amount of treatment is due to be paid by me and understand any direct billing to my insurance plan that comes back unpaid is to be paid promptly by me.

Patient/Parent/Guardian Signature: _____

_____ _____
Printed Name **Date**

Copyright © 2018 All Rights Reserved. Simply Dentures.