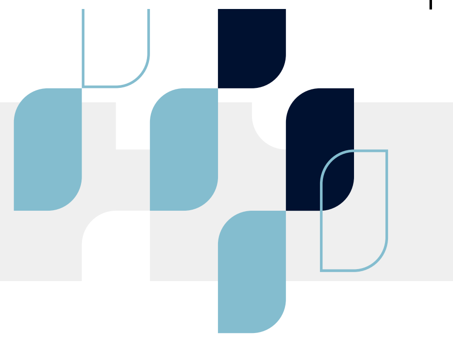


D³ CLINIC
DENTURE EXPERIENCE.

MEDICAL & DENTAL HISTORY FORM

Please fill out the following form to provide us with important information about your medical history, allergies, and current medications:

PERSONAL INFORMATION :

First Name :

Last Name :

Date of Birth : ☐☐ / ☐☐ / ☐☐ Gender : ☐ Male ☐ Female

Address :

Phone Number : Email :

Health Fund: Expiriy Date: ☐☐ / ☐☐

EMERGENCY CONTACT INFORMATION :

Name :

Relationship :

Phone Number :

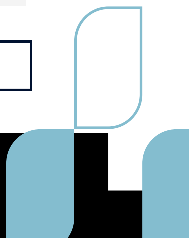
MEDICAL HISTORY

- ☐ Epilepsy
- ☐ Heart murmur
- ☐ Diabetes
- ☐ Heart valve disorder
- ☐ Stroke
- ☐ Psychological disorders
- ☐ Kidney disease
- ☐ Excessive bleeding
- ☐ Heart disease
- ☐ Thyroid disorder
- ☐ Blood Pressure
- ☐ Fanting / dizzines
- ☐ Cardiac pacemaker
- ☐ Hepititis
- ☐ HIV/AIDS virus
- ☐ Asthma

LIST OF MEDICATIONS TAKEN:

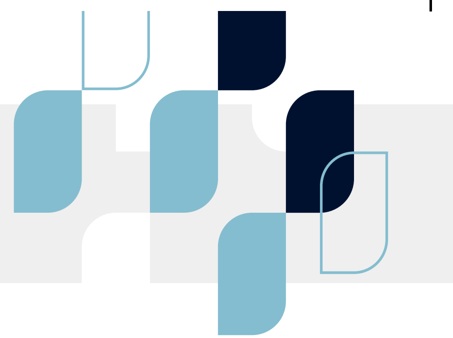
Known Allergies:

PLEASE TURN PAGE OVER TO COMPLETE FORM



D³ CLINIC

DENTURE EXPERIENCE.



DENTURE HISTORY

Last Examination:

Name of your Dentist: ☐☐ / ☐☐ / ☐☐

Do you wear full, partial or no Dentures? :

How old are your current Dentures? ☐ 0-3 Years ☐ 3-8 Years ☐ 8+ Years

Are you happy with the appearance of your current dentures? ☐ Yes ☐ No

Are your dentures ill fitting ? ☐ Yes ☐ No

Do you have difficulty chewing your food ? ☐ Yes ☐ No

Do you have any pain or discomfort now ? ☐ Yes ☐ No

What is the main purpose of todays visit ?

Terms And Conditions

- I confirm that all the information provided in this medical form is accurate and complete to the best of my knowledge.
- I understand that this information will be used to provide me with denture care and will be kept confidential.
- I agree to release and indemnify the healthcare provider from any liability arising from my medical treatment.
- I, the undersigned consent to the denture work being preformed as discussed in the consultation as agreed upon and am happy for treatment to proceed.
- I will assume responsibility for the fees associated with these procedures.
- I am aware D3 Denture Clinic require a 20% deposit for all new denture treatment at the first clinical appointment

Signature

Please sign here

Date :