Mile Zero Denture Clinic Patient Information

Please Print Clearly

Patient Full Name:_____

Preferred name:_____

Birth date (MM/DD/YY):_____

Mailing address:_____

City:_____Province:_____Postal Code:_____

Home phone#:_____

Cell phone#:_____

Work phone#:_____

Personal Health Care #:_____

Primary Insurance Company:_____

Group/Policy#:_____ID/Certificate#:_____

Secondary Insurance company:_____

Group/Policy#:_____ID/Certificate#:_____

Spouses Name (for insurance purposes only):_____

Spouses Birthdate (MM/DD/YY):_____

Emergency Contact Person Info:_____

How Did You Hear About Our Clinic? **Please specify name:**

Dentist (name)_____Friend (name)_____

Yellow Pages Online_____Yellow Pages Phonebook_____

Newspaper(which one)_____Signs/Billboards (location)_____

Other (please specify)_____

Dental Health History

Natural teeth-*complete the following section only if you have some or all of your natural teeth*

Do you have any dental work ongoing at this time? YES / NO

If YES, please specify_____

_____

Do you have any outstanding dental work that needs to be done? YES / NO

If YES, please specify_____

_____

Dentists Name_____

Do you experience chronic dry mouth? YES / NO

Do you have any sensitive teeth? YES / NO

Do you clench or grind your teeth? YES / NO

Do you gag easily? YES / NO

How often do you brush your teeth?

DAILY / WEEKLY / OTHER

How often do you floss your teeth?

DAILY / WEEKLY / OTHER

How often do you see a hygienist?_____

Denture Information-*complete the following section only if you have a denture or dentures*

Do you currently have a denture? YES / NO

If so, what type? Please check all that apply:

- Complete Upper
- Complete Lower
- Partial Upper
- Partial Lower

(Denture Info continued)

When were your dentures made? (Approximate date/dates if unsure)

Upper_____

Lower_____

Are you satisfied with your dentures?

_____

How many dentures have you had? _____

Do you use denture adhesives? YES / NO

Do you wear your dentures at night? YES / NO

Do you brush your gums under your denture(s)? YES/ NO

Do your gums get sores under your denture(s)? YES / NO

If YES, How often do the sores appear? Choose one: Occasionally / Daily / Weekly

Are you happy with the appearance of your dentures? YES / NO

If NO, what would you like to change?_____

_____

Do you have problems eating any particular types of food? YES/ NO

If yes, please specify_____

_____

Do you have Dental Implants? YES / NO

Have the benefits of Dental Implants been discussed with you? YES / No

Medical Health History

Are you currently under the care of a physician for a current health condition? YES / NO

If YES, what for? _____

_____

Please check any of the following health conditions that currently apply to you:

- o Alcohol Problems
- o Drug Dependency
- o Alzheimer's/ Dementia
- o Nervousness/ Psychiatric Condition
- o Depression
- o Asthma
- o Difficulty Breathing
- o Emphysema
- o COPD
- o Eating Disorder
- o Thrush
- o TMJ Disorder
- o Heart Surgery
- o Heart Attack
- o Stroke
- o Heart Disease
- o Bleeding Disorder/Haemophilia
- o Low Blood Pressure
- o High Blood Pressure
- o Dizziness/fainting
- o Epilepsy/Seizures
- o Sexually Transmitted Disease
- o HIV/AIDS
- o Immune Deficiency
- o Kidney Disease
- o Lupus
- o Herpes Virus(Cold Sores)
- o Parkinson's Disease
- o TMJ Disorder
- o Fibromyalgia
- o Hodgkin Disease
- o Tuberculosis
- o Hepatitis A/B/C
- o Thyroid Disease
- o Migraines
- o Arthritis
- o Cancer
- o Chemotherapy/Radiation Therapy
- o Diabetes Type 1 / Type 2
- o Environmental Allergies
- o Food Allergies

Are you allergic to any Metals, Latex or Acrylic?

_____

Have you recently lost or gained a significant amount of weight? YES / NO
If so, How much? _____

Have you ever had trauma or injury to your neck or jaws? YES/ NO

Do you smoke or use chewing tobacco? YES / NO

If so, what type and for how long? _____

_____

Mile Zero Denture Clinic Privacy and Billing Policies

NOTE TO CLIENT: We want your informed consent. This means that we want you to understand the services we hope to provide to you, the cost involved, and what we do with the personal information we obtain about you. If you have any questions with regard to our privacy policy, please ask.

CONSENT FOR PERSONAL INFORMATION

I understand that to provide me with the denture health care goods and services, the denturist will collect some personal information about me like, but not limited to, home address, telephone number, and medical history.

I understand that in accordance with this denturist's Privacy Policy, the collection and disclosure of my personal information will be protected and remain within the scope of this denturist's practice. I understand and agree that the denturist may use my address and telephone number to communicate to me within the scope of practice and in relation to the provision of denture health care.

I understand how the privacy policy applies to me and I have been given a chance to ask any questions I have about the Privacy Policies and they have been answered to my satisfaction.

SIGNATURE_____ DATE_____

BILLING POLICIES

For Complete, Partial and Implant Dentures a 50% Deposit is required at the start of treatment, (impression appointment). The remaining balance will be paid in full at the second last appointment, (Try-in appointment).

For Immediate Dentures, Relines and Repairs, full payment will be required at the first appointment. (All insurance claims will be sent in and payment issued to patient)

As a courtesy to our patients we will assist you with submitting insurance paperwork, which includes: pre-authorizing treatment plans and sending in claims. It is however the responsibility of you (the patient) to ensure treatment payment is made. * **A pre-authorization must be in place before we will begin treatment. The portion that your insurance company does not pay is due at the time of your first appointment, (impression appointment).**

We do not direct bill immediate dentures or repairs; payment is required up front, we will send in the insurance claim and payment will be issued to the patient.

* First Nations and Inuit Health (FNIH):
*We no longer accept pre-authorizations for FNIH, all procedures will have to be paid as per outlined above. We will submit a claim for you and all monies will be directed to you.

As a service to our patients we provide you with a **Warranty** when you receive your denture. It is your responsibility to receive the necessary service within the time frame spelled out in the warranty.

I have read and understand the above policies.

Signature:_____ Date:_____