Mr. Mrs.
Miss _____
Last First

Date: _____

Birth date: ☐☐ ☐☐ ☐☐
Month Day Year

Male ☐

Female ☐

Spouses name: _____

Address: _____ City: _____ Code: _____

Telephone Res. _____ Bus. _____ Refered by: _____

Physician: _____ Dentist: _____

Insurance Coverage yes / no

Denture Status: CUD: _____ CLD: _____ PUD: _____ PLD: _____ Dental Implants: _____

Immediate Dentures: _____

Dental Insurance / Billing Information

Dental Insurance Information:

Primary Carrier	Group / Policy #	Employee ID#	Dep.	Plan % A	Plan % B	Ded.	Other
		Cert.#					

Employer: _____ **Phone:** _____

Insurance variance notes: _____

Spouse name: _____ Birth date: ☐☐ ☐☐ ☐☐
Month Day Year

Secondary Carrier	Group / Policy #	Employee ID#	Dep.	Plan % A	Plan % B	Ded.	Other
		Cert.#					

Employer: _____ **Phone:** _____

Insurance variance notes: _____

Spouse name: _____ Birth date: ☐☐ ☐☐ ☐☐
Month Day Year

Denture / Dental History:

	Circle			Circle	
Do you chew well with your dentures?	yes	no	Does food get under your dentures?	yes	no
Do you wear your dentures at night?	yes	no	Do you grind or clench your teeth?	yes	no
Are your dentures loose?	yes	no	Are your dentures comfortable?	yes	no
If yes, do you mean ___both or ___ just one?			Do you gag easily?	yes	no
Age of present dentures? ___0 - 4 years			Do you chew mints/gum?	yes	no
___5 - 9 years			Were your present dentures made by a		
___10+ years			____denturist or ____dentist?		

How long have you been wearing dentures? _____

How many dentures have you had? _____

If you have any natural teeth remaining, when was your last visit with a dentist?_____

Please list the concerns you have with your present dentures:_____

_____

_____

_____

Please indicate the types of changes you would like to see with your new dentures:

☐ tooth size ☐ shape ☐ color ☐ bite position ☐ lip support ☐ no changes

Medical History

Circle

1. Are you being treated for any medical condition at present or within the past 5 years? yes no
   If so, please explain_____
   _____
2. Have you been injured or hospitalized in the last 2 years? yes no
   If so, please explain_____
3. Have you recently, or are you presently taking any prescription / nonprescription medications? yes no
   Please list:_____
4. Do you have any allergies that you are aware of?_____

   Are you allergic to any of the following:
   Latex gloves:_____
   Metals: _____
   Plastics: _____

5. Do any of these allergic conditions result in headache, swelling, shortness of breath, chest constriction, or a burning sensation in your mouth? yes no
6. Is there a family history of diabetes, heart disease, cancer or osteoporosis? yes no
7. Do you bleed excessively from a cut or bruise easily? yes no
8. Has your weight, appetite or energy level changed dramatically, recently? yes no
9. Do you follow a special diet? yes no
10. Do you smoke? yes no
11. Have you tested HIV positive? yes no
12. Have you tested positive for hepatitis A B C? yes no
13. **Do you wish to speak privately to the Denturist about any medical condition?** yes no

Do you have any of the following:

☐ Alzheimers	☐ Thyroid Disorder	☐ Radiation/Chemotherapy
☐ Anemia	☐ Head/Neck Injury	☐ Rheumatic Fever
☐ Arthritis	☐ Heart Disease	☐ Stroke
☐ Blood Transfusion	☐ High/Low Blood Pressure	☐ Thrush
☐ Cancer	☐ Hodgkins Disease	☐ TMJ Disorder
☐ Diabetes	☐ Hypo/Hyperglycemia	☐ Tuberculosis (TB)
☐ Emphysema	☐ Lupus	☐ Sexually Transmitted Disease (STD)
☐ Epilepsy or Siezures	☐ Migraines	☐ _____
☐ Fibromyalgia	☐ Parkinsons Disease	☐ _____
☐ _____	☐ _____	☐ _____

I, the undersigned, hereby certify the information given to me to be accurate, and I assume responsibility for all fees incurred."

Patient signature: _____ Date:_____