Kreze Denture Clinic New Patient Form

PATIENT INFORMATION

Name: ________________________________ Date Of Birth: ___________________________

Address: ______________________________ Martial Status: ___________________________

City: _________________________________ Postal Code: _____________________________

Phone: HOME: ______________ BUS: ______________ CELL: _________________

Email: ________________________________ Referred By: _____________________________

Occupation: ____________________________ Employer: _______________________________

INSURANCE INFORMATION

Ins. Co.: ______________________________ Policy #: ________________________________

Policy Holder Name: ____________________ Date of Birth (Policy Holder): ________________

Email (Policy Holder): ____

MEDICAL INFORMATION

Family Physician: ________________________ Tel. #: __________________________________

Are you currently under medical treatment?

Reason? ____

Last Visit? ____

Have you ever been treated for any of the following?

☐ Diabetes ☐ Repeat Headaches ☐ Hepatitis
☐ Epilepsy ☐ Stroke ☐ Artificial Joints
☐ Heart Condition ☐ Allergies (Metal/Latex) ☐ Emotional/Nervous Disorders
☐ High Blood Pressure ☐ Respiratory Disease/Asthma ☐ Asthma
☐ Cancer ☐ HIV/AIDS ☐ Thyroid

☐Other: ____

Are you currently taking any medication for this condition or any other reason?

☐ YES ☐ NO (Mark Rx where applicable and specify below)

DENTAL INFORMATION

Family Dentist: ______________________________ Tel. #: __________________________________

Type of Existing Denture: _____________________ Age of Existing Denture: __________________

Do you gums feel tender or sore? ____

Do you have any lumps or sores in your mouth at this time? ______________________________________

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

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