ADVANCED TECHNIQUE
DENTURE AND IMPLANT
SOLUTIONS

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Lethbridge
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403.320.5722

Coaldale
2209 20 Ave S, Coaldale AB, T1M 1J5
4013.405.1100

PERSONAL INFORMATION (Please Print)

Name of Patient:_____
(First) (Middle Initial) (Last)

Date of Birth:_____ □ MALE □ FEMALE
(Month/Day/Year)

Street/Mailing Address:_____

City:_____ Province: _____ Postal Code:_____

Home #:_____ Work #:_____ Cell #:_____

Email Address:_____

Employer:_____ Occupation:_____

Physician:_____ Phone #:_____

City:_____ Province:_____

Dentist:_____ Phone #:_____

City:_____ Province:_____

DENTAL INSURANCE

Primary Insurance
Name of Subscriber:_____ Date of Birth:_____
(First) (Middle) (Last) (Month/Day/Year)

Insurance Company:_____

Policy/Group #:_____ Certificate/ID #:_____

Secondary Insurance
Name of Subscriber:_____ Date of Birth:_____
(First) (Middle) (Last) (Month/Day/Year)

Insurance Company:_____

Policy/Group #:_____ Certificate/ID #:_____

IN CASE OF EMERGENCY

NOTIFY:_____Relationship to Patient:_____

Home #:_____ Cell #_____

DENTAL HISTORY

1. What was the date of your last dental/denture visit?_____
2. Have you had any dental x-rays within the last 2 to 5 years? □ No □Yes
3. Are you nervous about having dental treatment? □ No □Yes
4. Have you ever had complications after dental treatment? □ No □Yes
   *If Yes, please specify:*_____
5. Do you have any of the following:
   □ Aching or sensitive teeth
   □ Tender or swollen gums
   □ Unpleasant odor or taste in your mouth
   □ Other
   *If Other, please specify:*_____
6. Do you have any jaw or facial pain?_____
7. How important is it to you to keep your teeth? □ Very □ Moderately □ Not at all

MEDICAL HISTORY

8. When did you have your last medical examination? Date:_____
9. Do you currently have any health problems? □ No □Yes
10. Are you currently taking prescription drugs or medicine? □ No □Yes
    *Please specify type and reason for use:*_____
    _____
11. Do you ever experience hives or skin rashes? □ No □Yes
12. Do you smoke or use smokeless tobacco? □ No □Yes
13. Are your activities limited? □ No □Yes
14. Do you become breathless easily? □ No □Yes
15. Do you have heart disease or a heart murmur? □ No □Yes
16. Do you suffer from high blood pressure? □ No □Yes
17. Have you ever had rheumatic fever? □ No □Yes
18. Do you have abnormal bleeding or bruising? □ No □Yes
19. Are your ankles often swollen? □ No □Yes
20. Have you gained or lost excessive weight recently? □ No □Yes
21. Do you have diabetes? □ No □Yes
22. Do you have allergies? □ No □Yes
    If yes, list: _____
23. Are you allergic to latex?(Eg. Swollen lips after blowing a balloon) □ No □Yes
24. Do you have a reaction to jewelry? □ No □Yes
25. Are you allergic to any medicine or drugs? □ No □Yes
    If yes, list: _____
26. Have you had radiation therapy about the head and jaws? □ No □Yes
27. Do you have an eating disorder? □ No □Yes
28. Do you have thyroid disease? □ No □Yes
    If Yes, please specify: □ Hypo □ Hyper
29. To the best of your knowledge, are you in good health? □ No □Yes

30. Are you afflicted with, or have ever been treated for any of the following:

Ulcers/Stomach Problems	□ No □Yes	Cold Sores	□ No □Yes
Chest pain/Heart attack	□ No □Yes	Stroke	□ No □Yes
Epilepsy or Seizures	□ No □Yes	Anemia	□ No □Yes
Nervous tension	□ No □Yes	Blood disorders	□ No □Yes
Dizziness	□ No □Yes	Kidney disease	□ No □Yes
Asthma	□ No □Yes	Liver disease	□ No □Yes
Lung problems	□ No □Yes	Psychiatric care	□ No □Yes
Arthritis	□ No □Yes	Hepatitis	□ No □Yes
Cancer	□ No □Yes	Tuberculosis	□ No □Yes
Sinusitis	□ No □Yes	Mononucleosis	□ No □Yes
AIDS	□ No □Yes	Muscular dystrophy	□ No □Yes
HIV+	□ No □Yes	STD's	□ No □Yes

31. Do you have any disease, condition or problem not listed above? □ No □Yes
*If Yes, please specify:*_____

How did you hear about us? Check all that apply.

□ Yellow Pages □ Business sign □ Mailout Received
□ Facebook/Instagram □ TV Commercial □ Newspaper
□ Dentist Referral _____ □ Friend/Family Referral _____
□ Google: What did you type to find us: _____

CONSENT FOR TREATMENT

The signature of the patient is required for consent of treatment performed. It also signifies that you assume responsibility for the fees associated with your treatment. We require a 50% deposit for the treatment which is required on your second visit to Advanced Technique Denture & Implant Solutions and we collect the balance due from your insurance policy. If there is any overage owing to you we will provide a cheque to you upon receipt of the insurance payment to our office. Any outstanding fees after receipt of the insurance estimate will be payable by the patient prior to or upon completion of your treatment.

Date: _____ Patient Signature:_____ Denturist Signature:_____