



**ADVANCED TECHNIQUE
DENTURE AND IMPLANT
SOLUTIONS**

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Lethbridge

Coaldale

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403.320.5722

4013.405.1100

PATIENT 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 #: _____ Cell #: _____ Email: _____

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 #: _____

REFERRED FOR THE FOLLOWING

- Immediate Upper Denture
- Complete Upper Dentures
- Partial Upper Dentures
- Immediate Lower Denture
- Complete Lower Dentures
- Partial Lower Dentures
- Upper Implant Denture Solutions
- Lower Implant Denture Solutions

Extraction Date: _____ Tooth Numbers: _____

Comments: _____

Radiograph available No Yes

Referred by _____ Dental Office _____ Date _____