# ADVANCED TECHNIQUE DENTURE AND IMPLANT SOLUTIONS


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## 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:_____________