ADVANCED TECHNIQUE
DENTURE AND IMPLANT
SOLUTIONS

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2209 20 Ave S, Coaldale AB, T1M 1J5

PERSONAL INFORMATION

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

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

Street/Mailing Address:_____

City:_____ Province: _____ Postal Code:_____

Cell #:_____ Send me text reminders! □ No □Yes Home #:_____

Work #: _____Email:_____

Employer:_____ Occupation:_____

Physician:_____ Phone #:_____

Clinic:_____ City:_____

Dentist:_____ Phone #:_____

Clinic:_____ City:_____

DENTAL INSURANCE

Primary Insurance
Subscriber (if not patient):_____ Date of Birth:_____
(First) (Middle) (Last) (Month/Day/Year)

Company: _____

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

Secondary Insurance
Subscriber (if not patient):_____ Date of Birth:_____
(First) (Middle) (Last) (Month/Day/Year)

Company: _____

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

IN CASE OF EMERGENCY

NOTIFY:_____Relationship to Patient:_____

Phone #:_____

DENTAL & MEDICAL HISTORY

1. Do you currently have dentures? □ No □Yes
   *if yes: How old are your current dentures?*_____
   When was your last denture reline? _____
2. When was your last dental/denture visit?_____
3. Have you had dental x-rays within the last 2 to 5 years? ◙ No ◙Yes
4. Are you nervous about having dental treatment? ◙ No ◙Yes
5. Have you ever had complications after dental treatment? ◙ No ◙Yes
   *If Yes, please specify:*_____
6. Do you have any of the following: □ Aching or sensitive teeth
   □ Tender or swollen gums
   □ Unpleasant odor or taste in your mouth
   □ Jaw or facial pain
   □ Other: _____
7. How important is it to you to keep your teeth? □ Very □ Moderately □ Not at all
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, vape or use smokeless tobacco/cannabis? ◙ No ◙Yes
13. Are your activities limited? ◙ No ◙Yes
14. Do you become breathless easily? ◙ No ◙Yes
15. Do you have abnormal bleeding or bruising? ◙ No ◙Yes
16. Are your ankles often swollen? ◙ No ◙Yes
17. Have you gained or lost excessive weight recently? ◙ No ◙Yes
18. Do you have allergies? ◙ No ◙Yes
    If yes, list: _____
19. Do you have sulpha allergies? ◙ No ◙Yes
20. Do you have any reactions to jewelry? ◙ No ◙Yes
21. Have you had radiation therapy to the head and jaw? ◙ No ◙Yes
22. Are you afflicted with, or have ever been treated for any of the following:

Ulcers/stomach issues	◙ No ◙Yes	Cold Sores	◙ No ◙Yes	Asthma	◙ No ◙Yes
Chest pain/heart attack	◙ No ◙Yes	Stroke	◙ No ◙Yes	Dizziness	◙ No ◙Yes
Epilepsy/seizures	◙ No ◙Yes	Arthritis	◙ No ◙Yes	Cancer	◙ No ◙Yes
Eating disorder	◙ No ◙Yes	Tuberculosis	◙ No ◙Yes	AIDS	◙ No ◙Yes
Blood disorders	◙ No ◙Yes	Sinusitis	◙ No ◙Yes	HIV+	◙ No ◙Yes
Kidney disease	◙ No ◙Yes	Hepatitis	◙ No ◙Yes	STD's	◙ No ◙Yes
Liver disease	◙ No ◙Yes	Diabetes	◙ No ◙Yes	Dementia	◙ No ◙Yes
Lung problems	◙ No ◙Yes	Eating disorder	◙ No ◙Yes		
Muscular dystrophy	◙ No ◙Yes	Mononucleosis	◙ No ◙Yes		
High blood pressure	◙ No ◙Yes	Heart disease	◙ No ◙Yes		
Rheumatic fever	◙ No ◙Yes				
Thyroid disease	◙ No ◙Yes *If yes:* □ Hypo □ Hyper				

23. Do you have any medical conditions not listed above? □ No □Yes
    *If Yes, please specify:*_____

HOW DID YOUR HEAR ABOUT US?

Please check all that apply

□ TV Commercial □ Dentist Referral _____

□ Facebook/Instagram

□ Business sign □ Friend/Family Referral Name: _____

□ Yellow pages

□ Mailout □ Google: What did you search: _____

CONSENT FOR TREATMENT

The signature of the patient is required for consent of treatment performed.
I agree and understand that by signing, that all electronic signatures are the legal equivalent of my manual/handwritten signature and I consent to be legally bound to this agreement.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.

Patient Signature:_____ Date:_____

Denturist Signature:_____ Date: _____