To help us meet all your denture needs, please fill out this form completely.
If you have any questions or need assistance, please ask us-we will be happy to help.

Patient Information

Name_____ Age_____ Birthdate_____
Address_____ City_____ State_____ Zip_____
Phone Number_____ Email_____
Occupation_____ Employer_____ Work Phone_____

Who were you referred by _____
Person to contact in case of emergency_____

Check Appropriate Status:
Single___ Married___ Divorced___ Widowed___ Separated___ Minor___

Insurance Information

If MEDICAID, enter your MEDICAID number_____; present Medicaid card at desk.

If INSURED, Insurance Plan Name _____; present insurance card at desk.
Your Insurance ID# _____ Group# _____

If you are covered by someone else's insurance plan, provide that person's information below.
Name of Insurance Plan Holder _____ Birthdate _____
Relationship to patient _____ Phone _____

For Patients in Assisted Living/Nursing Home, or under care of a Legal Guardian:

Facility Name _____ Phone_____

Guardian/Power of Attorney/Person Responsible for Paying Bills of Patient*: (if other than self)*
Name_____Relationship_____
Address_____ City_____ State_____ Zip_____
Phone _____ Email_____

Denture Information

Do you wear dentures/partials now? _____ If yes, for how long?_____

How many sets of dentures/partials have you had? _____

How long have you worn your present dentures/partials _____

Have they been relined?_____ How many times _____ Last relined_____

What problems have you had in the past /OR do you have now with your dentures?

_____

_____

Health Information

Who is your Dentist _____ Last dental appointment _____

Are you under treatment of a Physician? YES NO
If YES, Physician's Name_____ Physician Phone _____

Please list all medications you are now taking: _____

_____

_____

Are you dissatisfied with the appearance of your present teeth?	**YES NO**
Do you have difficulty chewing your food?	**YES NO**
Have you had sores on your lips or mouth that are slow to heal?	**YES NO**
Do you have difficulty in opening your mouth wide?	**YES NO**
Do you use denture adhesives?	**YES NO**
Do you have difficulty with gagging when impressions are taken?	**YES NO**
Do you smoke, vape, or use tobacco?	**YES NO**

Do you have problems in the following areas—Past or Present?

Hepatitis	**YES NO**	**Excessive Bleeding?**	**YES NO**
Rheumatic Fever?	**YES NO**	**Frequent Headaches?**	**YES NO**
High Blood Pressure?	**YES NO**	**Diabetes?**	**YES NO**
Low Blood Pressure?	**YES NO**	**Heart Disease?**	**YES NO**
Cancer or Tumor?	**YES NO**	**Venereal Disease?**	**YES NO**
Fainting Spells?	**YES NO**	**Cold Sores?**	**YES NO**
Epilepsy	**YES NO**	**HIV (AIDS)**	**YES NO**
Stroke	**YES NO**		

*I understand that I am utilizing the services of a **denturist** and not a dentist.*
I understand that a denturist does not diagnose, evaluate, or treat any disease or malfunctions of oral cavity and that I should see a dentist or physician if such services are required.

Patient Signature_____ Date_____

Acknowledgment of Privacy Practices

Under

(HIPPA) Health Insurance Portability &Accountability Act of 1996

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability &Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly;
- Obtain payment from third-party payers for my health care services;
- Conduct normal health care operations such as quality assessment and improvement activities.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Print Patient Name: _____

Signature: _____

Date: _____

List any family members also covered by this acknowledgment: _____

Relationship to Patient: _____

For office Use Only:
We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to:
___ The patient refused to sign ___ Communication barriers ___ Emergency situation ___ Other