Patient Registration **Dentures-In-A-Day PLC, 6045 S. Division Ave, Grand Rapids, MI, 49548**

Name______________________________________ Home (   ) ______________

Cell# (   ) ____________ Birthdate ____________ *Email (optional)*______________________

Address______________________________ City________________ State________ Zip ________

Please circle: Male / Female Married Single Divorced Widowed

In Case of Emergency who should we contact____________________ **Phone Number(** **)**______________

Relationship____________________

Dental Insurance Information

Insurance Company____________________ **Insured Person's** Name____________________

Birthdate **of Insured Person**____________________ SSN# or Contract# of **Insured Person**____________________

Employer of **Insured Person**____________________ Work # & Best time to Contact ____________________

Have you ever had a bad reaction to any of the following drugs?

Aspirin....................................... Yes ____No____
Sulfa.. Yes ____No____
Penicillin.................................... Yes ____No____
Iodine... Yes____No____
Barbiturates (sleeping aids).... Yes ____No____
Local or General Anesthetics. Yes ____No____
Codeine...................................... Yes ____No____

Other Medicines (please list below)

____

List any medications you are taking now:

____

____

____

Have you had any of the following:
Please check yes or no.

Asthma...................................... Yes____No____
Artificial Joints.......................... Yes____No____
Blood Disorders......................... Yes____No____
Cancer.. Yes____No____
Diabetes..................................... Yes____No____
Glaucoma................................... Yes____No____
Heart Attack...............................Yes____No____
Heart Murmur........................ Yes____ No____
Hepatitis A__B__C__...............Yes____No____
High Blood Pressure.............. Yes____ No____
HIV.. Yes____No____
Neurological disorders........... Yes____No____
Pacemaker.................................. Yes____No____
Rheumatic Fever .... Yes____No____
Stroke.. Yes____No____
Tuberculosis.............................. Yes____No____
Venereal Disease .... Yes____No____

Are you being treated for any condition by a physician now? Yes____No_____

Have you lost a lot of weight in the past year without dieting? Yes____No_____

Have you ever been hospitalized for a facial or jaw fractures? Yes____No_____

Are you wearing dentures or partials now? Yes____No_____

Are you satisfied with the appearance of your dentures/partials? Yes___No_____

Do you have difficulty chewing your food? Yes____No_____

Do you sleep with your dentures or partials? Yes____No_____

Does your lower denture or partial cause you soreness? Yes____No_____

Do you use denture adhesives or drug store liners? Yes____No_____

How old are your dentures or partials? Month/Year

____

Have you been examined by your physician within the last year? Yes____No____

Are you Pregnant? Yes____No_____

How did you hear about us? ***Please Circle:*** TV Phone Book Radio Web Friend Other

Is there any condition or surgery that you have or had that requires you to take an antibiotic before dental work? Yes____No_____

Patient's Signature______________________________ **Date**_____/_____/_____