NEW DENTURE PATIENT CONSULT FORM(Confidential and Necessary) Date: _____-_____-_____

Name____Birth Date:______-______-_______ Age:_____

Home Address____City______________State______ZIP________

Phone Numbers: Home:_____-_____-_______ Work:_____-_____-_______ ext:______ Cell: _____-____-______

e-Mail_____________________@____________________ S.S. #:_____-_____-______ Marital Status: S M D

Your Employer______________________________Position____________________How Long?___________

Employer's Address________________________________City______________State_______ZIP___________

Spouse/Parent/Guardian (circle one)____

Their Employer______________________________Position____________________How Long?__________

Nearest Living Relative NOT living with you______________________________Relationship_______________

Their Phone Number______-______-________ City___________________________State__________________

Whom should we call in an emergency?________________________________Phone:_____-_____-___________

Physican____Phone:_____-_____-___________

Person responsible for this account_______________________________________ (signature)

DENTAL INSURANCE INFORMATION (to process your claim)

Primary Dental Ins. Co.____________________________________Employer_________________Group #_____

Phone_____-_____-_______ Annual Benefit Maximum________________Annual Deductible________________

Employee's Name_______________________________ S.S. # _____-_____-_______ Birthdate____-____-______

Whom may we thank for this referral (or How did you find out about us)?_________________________________

Please answer the following questions so that we may help you:

1. Do you currently wear dentures? Yes No
2. If yes, how long have you worn dentures? ________Years
3. How old is this set of dentures? ________Years
4. Do you have any of your natural teeth? Yes No
5. If you have natural teeth, are they giving you any problems? Yes No
6. What concerns do you have about your existing, or getting a new denture? ______________________
7. Are you happy with the looks of your old denture? Yes No
8. If No, what would you change? ____
9. How long has it been since you have had an exam at the dentist? ___________________________

DATE **TREATMENT NOTES**