GEORGETOWN DENTURE CLINIC

Creating Confident Smiles Since 1982!

905•877•2359

PATIENT HISTORY

Name: _____ Date of Birth (m/d/y): ____/_____/_____

Address: _____Apt/Unit/Suite: _____

City/Town: _____Postal Code: _____

Main Phone No.: _____Alternate Phone No.: _____

Email: _____Have we seen you before? ○ YES ○ NO

How did you hear about us? _____

What type of dentures do you have now? ○ No dentures now ○ Full upper denture ○ Partial upper denture ○ Full lower denture ○ Partial lower denture

Approximately how old is / are your denture(s)? _____ Upper _____ Lower

Do you use denture adhesives? ○ YES ○ NO

Do your gums feel sore or tender? ○ YES ○ NO

Do you have any lumps or sores in your mouth at this time? ○ YES ○ NO

Briefly explain the main problems you are having with your dentures: _____

_____

Do you have a regular Dentist? ○ YES (if yes) – Dr. _____ ○ NO

Approximately when was the last time you were at the Dentist? _____

Approximately when was the last time teeth were extracted? _____Upper _____Lower

Do you have Dental Insurance? ○ YES ○ NO

I give consent to the collection, use, and disclosure of my personal information for the sole purpose of the services rendered, including continuing care, by Alexander Trenton, Denturist, and Jennifer Bisson, Denturist and Associates/Staff of the Georgetown Denture Clinic.

Signature: _____ Date: _____