PATIENT CHART
(Please Print)

______________________ ____ __________________________________ Birthdate:____/___/____
First Name **MI** **Last Name** MM DD YYYY

Preferred Name: _______________________________ **Email:** ____________________________________

Home Phone:______________________ **Cell Phone:**______________________

Mailing Address ______________________________ **City** ______________________ **State** ____**Zip** _______

Employer ______________________________________ **Work Phone**_______________________________

Spouse's Name _________________________________ **Spouse's Phone**____________________________

Who Referred You? ☐ **Name:**______________________ ☐ **Phonebook** ☐ **Internet** ☐ **Other** _______________

Emergency Contact (Other than Spouse): _____________________________ **Phone:** ___________________

CURRENT DENTAL STATUS

Do you have remaining Natural Teeth? ☐ Yes ☐ No

If YES ➔ Date of last Dental Exam _________________ Dentist ________________________________

Will this be your first denture/partial? ☐ Yes ☐ No ☐ I have one but do not wear it.

If **NO**, please proceed to "CURRENT DENTURE ASSESSMENT" below…If **YES, SKIP THIS SECTION**

CURRENT DENTURE ASSESSMENT

➔ Existing Denture Status: ☐ Full Upper ☐ Full Lower ☐ Partial Upper ☐ Partial Lower

Placement Date of Existing Denture/Partial:___________________________

	Circle			Circle	
Do you chew well with your dentures?	Yes	No	Does food get under your dentures	Yes	No
Are your dentures comfortable?	Yes	No	Do you wear your dentures at night?	Yes	No
Do you grind or clench your teeth?	Yes	No	Are your dentures loose?	Yes	No
Do you gag easily?	Yes	No	If yes, is it ___upper, ___lower, or ___both?		
Do you chew mints/gum?	Yes	No			

Please list the concerns you have with your present dentures ____

____

Please indicate the types of changes you would like to see with your new dentures:
☐ tooth size ☐ shape ☐ color ☐ bite position ☐ lip support ☐ no changes

PRIVACY RELEASE

I authorize Bellingham & Lynden Denture Clinics to speak to the following individuals regarding my care:

Name	Phone Number

FINANCIAL RESPONSIBILITY

Although treatment may be covered by insurance, the responsibility of all charges belongs to the patient.
If for any reason, payment is denied from the insurance company, you will be responsible for the denied charges.
I understand that I am personally responsible for all charges whether covered by insurance or not.

____ __________________________
Signature of Patient or Responsible Party **Date**

Please Fill Out Reverse Side

Bellingham DENTURE CLINIC

Lynden DENTURE CLINIC

PATIENT MEDICAL HISTORY

Yes No	Are you being treated for any major medical condition at present or within the past 5 years? Please explain:
Yes No	Have you been injured or hospitalized in the last 2 years? If yes, please explain:
Yes No	Have you recently, or are you presently taking any prescription/non-prescription medications? Please list (or provide a list):
Yes No	Please list any allergies you have: ________________ Are you allergic to any of the following? ☐ Latex Gloves ☐ Metals ☐ Plastic ☐ Sulfa Do any of these allergic conditions result in headache, swelling, shortness of breath, chest constriction, rash or a burning sensation in your mouth? ☐ Yes ☐ No
Yes No	Do you wish to speak privately to the Denturist about any medical conditions?
Yes No	Do you bleed excessively from a cut or bruise easily?
Yes No	Recently has your weight, appetite or energy level changed dramatically?
Yes No	Do you follow a special diet?
Yes No	Do you smoke?
Yes No	Have you tested positive for HIV?
Yes No	Have you tested positive for Hepatitis A, B, or C?

Do you have any of the following (please mark):

☐ Alzheimer	☐ Epilepsy or Seizures	☐ Lupus	☐ Sexually Transmitted Disease (STD)
☐ Anemia	☐ Fibromyalgia	☐ Migraines	☐ Thrush
☐ Arthritis	☐ Head/Neck Injury	☐ Osteoporosis	☐ Thyroid Disorder
☐ Blood Transfusion	☐ Heart Disease	☐ Parkinson's Disease	☐ TMJ Disorder
☐ Cancer	☐ High/Low Blood Pressure	☐ Radiation/Chemotherapy	☐ Tuberculosis (TB)
☐ Diabetes	☐ Hodgkin’s disease	☐ Rheumatic Fever	
☐ Emphysema	☐ Hypo/Hyperglycemia	☐ Stroke	

Please read carefully, and sign below as your acknowledgement of the following:

- I fully understand that I am utilizing the services of a DENTURIST and not a dentist.
- To the best of my knowledge, I have no health problems which would impair my wearing of dentures.
- I have been informed of my dental provider’s *Notice of Privacy Practices* and how it is used.
- I authorize Bellingham and/or Lynden Denture Clinic to coordinate treatment with my dental providers.
- I am aware of the 24 hour policy on appointments, and that I need to notify 24 hours in advance to change or break appointment.

______________________________ ______________________

Signature of Patient or Responsible Party Date