1ST CLASS DENTURES

6023 N Eagle Rd Ste 150
Boise, ID 83713
208-336-8873

PATIENT INFORMATION

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____

Emergency Contact _____ Relationship _____ Phone _____

Physician's Name _____ Dentist's Name _____

Dental Insurance Information (Primary)

Insurance Co. _____ Address _____

Primary Subscriber _____ Date of Birth _____ SSN# _____

Employer _____ Occupation _____ Work Phone _____

Subscriber ID # _____ Group ID # _____

Dental Insurance Information (Secondary)

Insurance Co. _____ Address _____

Primary Subscriber _____ Date of Birth _____ SSN# _____

Employer _____ Occupation _____ Work Phone _____

Subscriber ID # _____ Group ID # _____

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the named denturist or dental entity. Signature _____ Date _____

What is your reason for seeking care at this time: _____

_____

Do you have regular dental checkups? Yes / No When was your last dental exam: _____

Have you ever had serious trouble during previous dental treatment? Yes / No

Have you ever had sores on your lips or mouth that are slow to heal? Yes / No

Are you dissatisfied with the appearance of your teeth? Yes / No

Do you have difficulty chewing your food? Yes / No

Have you ever had injuries to your face or jaw? Yes / No

Do your jaws "pop" or "lock" when opening your mouth wide? Yes / No

Do you have any pain or discomfort now? Describe: _____ Yes / No

Do you wear Dentures/Partials? Yes / No If Yes, How old are they? _____

Do you sleep with your denture? Yes / No

Give your own opinion of the problems you are having with your dentures: _____

_____

_____

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Patient Medical History

Do you have or have you had any of the following? Please circle

High Blood Pressure	Diabetes	Cardiac Pacemaker
Rheumatic Fever	Angina	Cancer
Stomach Troubles / Ulcers	Hay Fever / Allergies	Respiratory Problems
Low Blood Pressure	Kidney disease	Heart Murmur
Swollen Ankles	Emphysema	Arthritis
Chest Pains	Tuberculosis	Hepatitis
Epilepsy / Convulsions	AIDS or HIV infection	Heart Attack
Fainting / Seizures	Glaucoma	Fibromyalgia
Easily Winded	Radiation Therapy	Herpes
Leukemia	Heart Disease	Joint Replacement or Implant
Asthma	Liver Disease	
Stroke	Recent Weight Loss	

Others not listed: _____

Are you allergic to Latex? Yes / No

Do you smoke or use tobacco? Yes / No

Do you smoke or use marijuana? Yes / No

Do you have dry mouth? Yes / No

Please list all the medications you are taking: _____

_____

Please list any vitamins you are taking: _____

_____

Please list any allergies: _____

_____

How did you hear about our office?

Friend/Family _____ Internet _____ Radio _____ Dentist _____

Other _____

I fully understand that I am using the services of a Denturist, not a dentist. I understand that a Denturist does not diagnose, evaluate or treat any diseases or malfunctions of the oral cavity and I should see a dentist or physician if such services are required.

Signature _____ Date: _____