RECORD RIDGE DENTURE CLINIC

PATIENT INFORMATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:	First name:	Birth date:	
Address:	City:	Postal Code:	
Home phone no.: ( )	Cell phone no.: ( )	Email:	
Secondary Contact/ Emergency Contact no: ( )	Name of contact:	Relationship to you:	
Physician:	Dentist:	Personal Health Number (if applicable):	

Chose clinic because/Referred to clinic by (please check one box):		❑ Dr._____	❑ Family/Friend	❑ Google
❑ Pennywise	❑ Yellow Pages	❑ Information Directory	❑ Trail or Castlegar Taxi Ad	❑ _____

CURRENT DENTURES

What do you have for dentures:

Upper:	❑ Complete	**Lower:** ❑ Complete
	❑ Partial	❑ Partial
	❑ Dental Implants	❑ Dental Implants

Approximately how old are your current dentures:

Who made your current dentures:

Please list any concerns you have with your current dentures:

CONSENT

The above information is true to the best of my knowledge. I consent to open communication between my denturist and dentist while completing my proposed treatment plan. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Record Ridge Denture Clinic to release any information required to process my claims.

Patient signature	*Date*