PATIENT INFORMATION I Please Print Clearly

Find us on f

Patient full name: ____________________

Preferred name: ____________________

Birth date (MM/DD/YY): ____________________

Mailing address: ____________________

City: __________ **Province:** __________ **Postal code:** __________

Home phone#: __________ **Cell phone#:** __________

Work phone#: __________ **Email:** __________

Emergency contact name and #: ____________________

If applicable, name and number of main contact for patient (if the patient needs assistance or has a power of attorney):

____

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Personal health care #: ____________________

Primary insurance company: ____________________

Group/policy#: __________ **ID/certificate#:** __________

Secondary insurance company: ____________________

Group/policy#: __________ **ID/certificate#:** __________

Spouses name (for insurance purposes only if spouse is the main cardholder):

Spouses birthdate (MM/DD/YY): ____________________

By signing here, you are giving Mile Zero Denture Clinic the right to contact your insurance company on your behalf.

Signature: __________ **Date:** __________

HOW DID YOU HEAR ABOUT OUR CLINIC? Please specify name:

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Are you allergic to any metals, latex or acrylic?: ____________________

Any other allergies?: ____________________

Name of dentist?: ____________________

Age of existing denture?: ☐ 0-4 Years ☐ 5-9 Years ☐ 10+ Years

Type of denture? (check all that apply): ☐ Complete Upper ☐ Complete Lower ☐ Dental Implants

☐ Partial Upper (metal framework) ☐ Partial Lower (metal framework)

☐ Acrylic Partial Upper (no metal) ☐ Acrylic Partial Lower (no metal)