—COMPLETE—
Denture Center LLC

107 Bridge St.
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207-860-2781
Paul Lalicata LD

PATIENT INFORMATION

Last Name:________________ First Name: ______________ Middle: ________

Address: ______________________________ City: ______________

State: ____________ Zip: ____________ Home Phone: ____________

Work Phone: ______________ Birth Date: __________ Sex: M / F

Age of Denture: __________

Date of Extractions: ____________ Who referred you to our practice? __________

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Patient Contractual Agreement

Upon entering into treatment at this practice, I the patient, understand that the services being provided to me are for denture therapy and I am not just purchasing a denture or dentures. I understand that my treatment involves not only the appliances themselves and professional expertise, but also my active participation in my own treatment. It is my understanding that compliance with the patient education I am provided, return visits and patience will be required for successful treatment. I am aware that should I choose to unduly delay or abandon my treatment, at minimum, the cost of the initial deposit of my treatment will be retained for expenses and professional time.

Patient Signature: ______________________________ Date: ____________

OVER

PATIENT MEDICAL HISTORY

PHYSICIAN ________________ OFFICE PHONE ________________ DATE OF LAST EXAM ________________

Answer yes or no.

Are you under medical treatment now?

Have you ever been hospitalized for any surgical Operation or serious illness?

Are you taking any medication(s) including Non-prescription medicine?

If yes, what medication(s) are you taking? ________________

Do you use tobacco?

Do you use alcohol, cocaine, or other drugs?

Are you allergic to or have you had any reactions to the following?

- Local anesthetics (ie. Novocaine)
- Barbiturates
- Aspirin
- Sedatives
- Penicillin or other antibiotics
- Sulfa drugs
- Iodine
- Other ________

Do you have or have you had any of the following? (Circle all that apply)

- High Blood Pressure
- Heart Attack
- Rheumatic Fever
- Swollen Ankles
- Fainting / Seizures
- Asthma
- Low Blood Pressure
- Epilepsy / Convulsions
- Leukemia
- Diabetes
- Kidney Diseases
- AIDS or HIV Infection
- Thyroid Problem
- Heart Disease
- Cardiac Pacemaker
- Heart Murmur
- Angina
- Frequently Tired
- Anemia
- Emphysema
- Cancer
- Arthritis
- Joint Replacement or Implant
- Hepatitis / Jaundice
- Sexually Transmitted Diseases
- Stomach Troubles / Ulcers
- Chest Pains
- Easily Winded
- Stroke
- Hay Fever / Allergies
- Tuberculosis
- Radiation Therapy
- Glaucoma
- Recent Weight Loss
- Liver Disease
- Heart Trouble
- Respiratory Problems
- Other ________________

PATIENT DENTAL HISTORY

Answer yes or no to the following.

Do your gums bleed while brushing or flossing?

Are your teeth sensitive to hot or cold liquids / foods?

Are your teeth sensitive to sweet or sour liquids / foods?

Do you feel pain to any of your teeth?

Do you have any sores or lumps in or near your mouth?

Have you had any head, neck or jaw injuries?

Have you ever experienced any of the following Problems in your jaw?

- Clicking?
- Pain (joint, ear, side of face)?
- Difficulty in opening or closing?
- Difficulty in chewing?

Do you have frequent headaches?

Do you clench or grind your teeth?

Do you bite your lips or cheeks frequently?

Have you ever had any difficult extractions in the past?

Have you had any orthodontic work?

Have you ever had prolonged bleeding following extractions?

Have you ever had instruction on the correct method of brushing Your teeth?

Have you ever had instructions on the care of your gums?

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature X ________________________________ Date: ________________