MR. MRS. DATE _____

MISS _____ BIRTHDAY _____ / _____ / _____ MALE ❑ FEMALE ❑
LAST FIRST MONTH DAY YEAR

ADDRESS _____ CITY _____ CODE _____

TELEPHONE RES. _____ BUS. _____ REF. BY _____

DOCTOR _____ DENTIST _____

MISCELLANEOUS INFO. _____

	CARRIER	GROUP NO.	EMPLOYEE IDENTITY NO.	DEP.	BIRTH MO.	BIRTH YR.	SEX	PLAN %
INSURANCE CARRIERS							MALE ❑ FEMALE ❑	A_____ B_____ C_____

	CARRIER	GROUP NO.	EMPLOYEE IDENTITY NO.	DEP.	PLAN %
DUAL COVERAGE					A_____ B_____ C_____

INSURANCE VARIATION NOTES: _____ AGE OF PREVIOUS DENTURES: _____ YRS.

MEDICAL HISTORY

IT IS MOST IMPORTANT THAT YOU ANSWER EVERY QUESTION

HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN RECENTLY? YES ❑ NO ❑

HAVE YOU EVER HAD ANY SERIOUS ILLNESS OR SURGERY? YES ❑ NO ❑

DIABETES OR EPILEPSY	YES ❑ NO ❑	HEPATITIS	YES ❑ NO ❑		
RADIATION TREATMENT	YES ❑ NO ❑	TUBERCULOSIS	YES ❑ NO ❑		
ALLERGIES OR ARTHRITIS	YES ❑ NO ❑	HEART DISEASE	YES ❑ NO ❑		
RHEUMATIC FEVER	YES ❑ NO ❑	HIGH BLOOD PRESSURE	YES ❑ NO ❑		
MEDICATIONS _____	YES ❑ NO ❑	VENEREAL DISEASE	YES ❑ NO ❑		

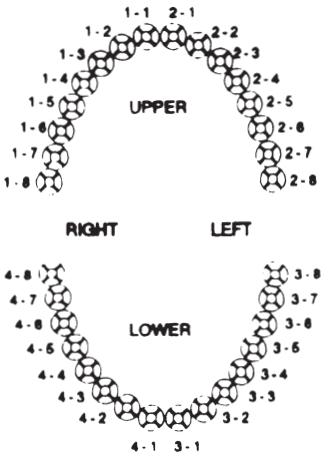
HAVE YOU BEEN TESTED FOR ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) YES ❑ NO ❑

DENTAL HISTORY

DO YOU SMOKE	YES ❑ NO ❑	ARE YOUR DENTURES LOOSE	YES ❑ NO ❑
CHEW WELL WITH YOUR DENTURES	YES ❑ NO ❑	DENTURES COMFORTABLE	YES ❑ NO ❑
GET FOOD UNDER YOUR DENTURES	YES ❑ NO ❑	DO YOU GAG EASILY	YES ❑ NO ❑
WEAR DENTURES ALL THE TIME (DAY-NIGHT)	YES ❑ NO ❑		
STIFF NECK OR SHOULDER MUSCLES	YES ❑ NO ❑		
SATISFIED WITH THE LOOKS OF YOUR DENTURES	YES ❑ NO ❑		

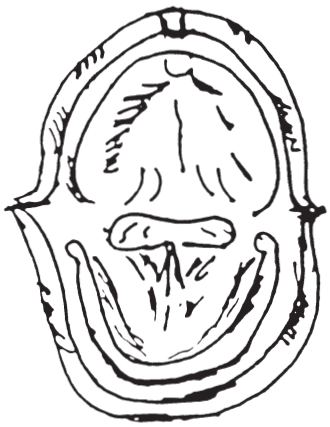
DATE: _____ SIGNATURE: _____

DENTITION CHART



INDICATE MISSING TEETH WITH AN 'X'

PATHOLOGY



NOTES: _____

DENTAL HISTORY:
T.M.J. [ ] _____
BRUXING [ ] _____

MAXILLARY RIDGE:
(GOOD, FAIR, POOR)
PALATE SHAPE _____
ANT HEIGHT ____G ____F ____P - WITH ____G ____F ____P
POST HEIGHT ____G ____F ____P - WITH ____G ____F ____P

MANDIBULAR RIDGE:
ANT HEIGHT ____G ____F ____P - WITH ____G ____F ____P
POST HEIGHT ____G ____F ____P - WITH ____G ____F ____P

DEPTH RETRO MYLOHYOID FOSSAE
DEPTH BUCCAL SEATING _____
DEPTH ANT. SEATING _____

BITE:
RE [ ] PRO [ ] CROSS [ ]NORM [ ]

NAME _____

INCISAL LENGTH

UPPER C_____ L_____ C_____ SHADE_____ PRESENT UPPER _____ LOWER_____

LOWER C_____ L_____ C_____ SHADE_____ NEW UPPER _____ LOWER_____

POSTERIOR_____ MATERIAL_____ FREEWAY SPACE OLD_____ NEW_____

TRY-IN APPROVED DATE:_____ SIGNATURE:_____

DATE	DESCRIPTION	FEE	PATIENT	PLAN	BALANCE

POST DELIVERY PROBLEMS

DATE OF ADJUSTMENT:

COMPLAINTS FROM PATIENT:

MEMO: