Mr. Mrs.
Miss _____
Last First

Date: _____
Birth date: ☐☐ ☐☐ ☐☐
Month Day Year

Male ☐
Female ☐

Spouses name: _____

Address: _____ City: _____ Code: _____

Telephone Res. _____ Bus. _____ Refered by: _____

Physician: _____ Dentist: _____

Insurance Coverage: yes / no

Denture Status: CUD: _____ CLD: _____ PUD: _____ PLD: _____ Dental Implants: _____

Immediate Dentures: _____

Dental Insurance / Billing Information

Dental Insurance Information:

Primary Carrier	Group / Policy #	Employee ID#	Dep.	Plan % A	B	Ded.	Other
		Cert.#					

Employer: _____ Phone: _____

Insurance variance notes: _____

Spouse name: _____ Birth date: ☐☐ ☐☐ ☐☐
Month Day Year

Primary Carrier	Group / Policy #	Employee ID#	Dep.	Plan % A	B	Ded.	Other
		Cert.#					

Employer: _____ Phone: _____

Insurance variance notes: _____

Spouse name: _____ Birth date: ☐☐ ☐☐ ☐☐
Month Day Year

Financial Record

Date	Service	Fee	Patient	Plan	Balance

Medical History

	Circle	
1. Are you being treated for any medical condition at present or within the past 5 years?	yes	no
If so, please explain _____		
_____		
2. Have you been injured or hospitalized in the last 2 years?	yes	no
If so, please explain _____		
3. Have you recently, or are you presently taking any prescription / nonprescription medications?	yes	no
If so, please explain _____		
4. Do you have any allergies that you are aware of? _____		
Are you allergic to any of the following:		
Latex gloves: _____		
Metals: _____		
Plastics: _____		
5. Do any of these allergic conditions result in headache, swelling, shortness of breath, chest constriction, or a burning sensation in your mouth?	yes	no
6. Is there a family history of diabetes, heart disease, cancer or osteoporosis?	yes	no
7. Do you bleed excessively from a cut or bruise easily?	yes	no
8. Has your weight, appetite or energy level changed dramatically, recently?	yes	no
9. Do you follow a special diet?	yes	no
10. Do you smoke?	yes	no
11. Have you tested HIV positive?	yes	no
12. Have you tested positive for hepatitis A B C?	yes	no
13. Do you wish to speak privately to the Denturist about any medical condition?	yes	no

Do you have any of the following:

☐ Alzheimer's	☐ Thyroid Disorder	☐ Radiation/Chemotherapy
☐ Anemia	☐ Head/Neck Injury	☐ Rheumatic Fever
☐ Arthritis	☐ Heart Disease	☐ Stroke
☐ Blood Transfusion	☐ High/Low Blood Pressure	☐ Thrush
☐ Cancer	☐ Hodgkin's Disease	☐ TMJ Disorder
☐ Diabetes	☐ Hypo/Hyperglycemia	☐ Tuberculosis (TB)
☐ Emphysema	☐ Lupus	☐ Sexually Transmitted Disease (STD)
☐ Epilepsy or Seizures	☐ Migraines	☐ _____
☐ Fibromyalgia	☐ Parkinson's Disease	☐ _____
☐ _____	☐ _____	☐ _____

I, the undersigned, hereby certify the information given by me to be accurate, and I assume responsibility for all fees incurred.

Patient signature: _____ Date: _____

Denture / Dental History

Name: _____

	Circle	
Do you chew well with your dentures?	yes	no
Do you wear your dentures at night?	yes	no
Are your dentures loose?	yes	no
If yes, do you mean ____ both or ____ just one?		
Age of present dentures? ____ 0-4 years		
____ 5-9 years		
____ 10+ years		

	Circle	
Does food get under your dentures?	yes	no
Do you grind or clench your teeth?	yes	no
Are your dentures comfortable?	yes	no
Do you gag easily?	yes	no
Do you chew mints/gum?	yes	no
Were your present dentures made by a		
____ denturist or ____ dentist?		

How long have you been wearing dentures? ____

How many dentures have you had? ____

If you have any natural teeth remaining, when was your last visit with a dentist? _____

Please list the concerns you have with your present dentures: _____

_____

_____

_____

Please indicate the types of changes you would like to see with your new dentures:

☐ tooth size ☐ shape ☐ colour ☐ bite position ☐ lip support ☐ no changes

Evaluation of present dentures:

Date: _____

Interocclusal distance _____ mm

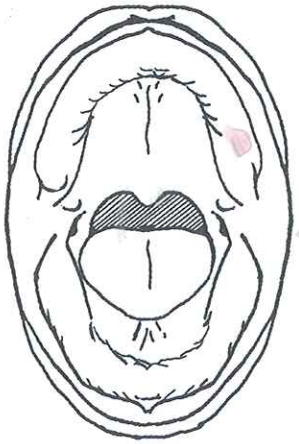
Lateral excursive movements	Good ____	Fair ____	Poor ____
Protrusive excursive movements	Good ____	Fair ____	Poor ____
Esthetic appearance	Good ____	Fair ____	Poor ____
Denture stability -upper	Good ____	Fair ____	Poor ____
- lower	Good ____	Fair ____	Poor ____
Condition of occlusal surfaces	Good ____	Fair ____	Poor ____
Condition of denture base acrylic	Good ____	Fair ____	Poor ____
Type of occlusion 0 10 20 33	other ____		

Tooth composition:

Posteriors: Plastic Resin Porcelain

Anteriors: Plastic Resin Porcelain

Oral Pathology Chart



Notes: _____

_____

_____

_____

_____

_____

_____

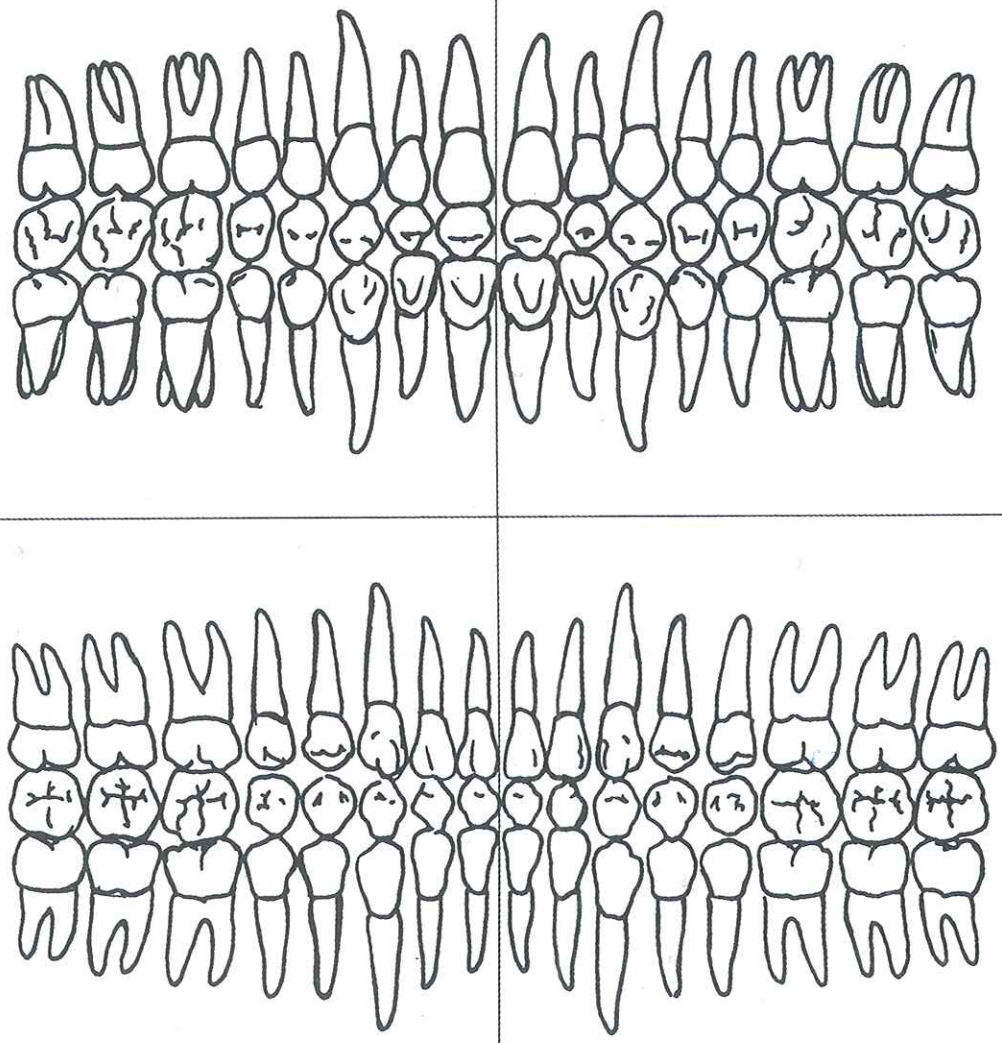
Date of examination: _____

Clinical Examination

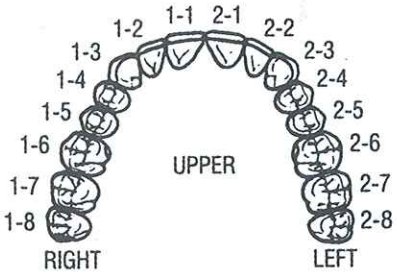
	CLASS I	CLASS II	CLASS III
General Health of Patient (cursory observation)	Good	Acceptable	Poor
Patient's ability to communicate	Good	Acceptable	Poor
General condition of oral environment	Healthy	Acceptable	Poor
TMJ - Vertical movement	Good	Acceptable	Poor
TMJ - Lateral movement	Good	Acceptable	Poor
Interarch relationship - posterior	Normal	Unilateral Crossbite	Bilateral Crossbite
Interarch relationship - anterior	Normal	Retrognathic	Prognathic
Height of maxillary ridge	Adequate	Some resorbtion	Badly resorbed
Height of mandibular ridge	Adequate	Some resorbtion	Badly resorbed
Shape of maxillary ridge	Supportive	Tapering	Inadequate
Shape of mandibular ridge	Supportive	Tapering	Inadequate
Arch form - maxillary	Square	Tapering	Ovoid
Arch form - mandibular	Square	Tapering	Ovoid
Relative arch size Mandible to Maxilla	Normal	Maxilla larger	Mandible larger
Contour of palatal vault	Broad & flat	U - shaped	V - shaped
Contour of soft palate	Gradual	More sloping	Drops sharply
Maxillary tori	Absent	Not significant	Significant
Mandibular tori	Absent	Not significant	Significant
Interarch distance	Average	Excessive	Restricted
Bony undercuts	Absent	Small	Prominent Bilateral
Arch parallelism	Parallel	Maxilla divergent	Mandible Divergent
Maxillary soft tissue	Firm (1 m/m)	Over (1 m/m)	Flabby
Mandibular soft tissue	Firm (1 m/m)	Over (1 m/m)	Flabby
Mucosa	Healthy	Irritated	Pathologic
Tissue border attachment	Favorable	Restricted	Inadequate
	> 12 m/m	8-12 m/m	< 8 m/m
Frenal attachments - lengths	Low	Medium	High
Frenel attachments - shape	Broad	Thin	Multiple
Lateral throat form	> 5 m/m	< 5 m/m	Level
Tuberosities	Supportive	Distorted	Inadequate
Saliva	Normal	Excessive	Minimal
Palatal sensitivity	No response	Minor discomfort	Violent gagger
Tongue size	Favorable	Unfavorable	Excessive
Tongue mobility	Normal	Excessive	Restricted
Patient attitude	Adjusted	Exacting	Maladjusted
Radiographic examination	Not required	Advisable	Necessary
Photographic	Requested	Yes	No

1. **Use highliter to indicate appropriate box.**
2. **Once evaluation is complete <u>do not</u> alter form.**

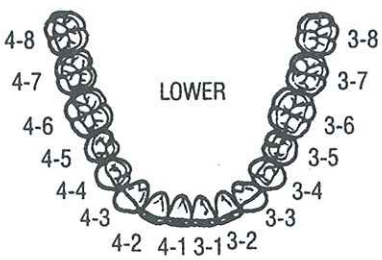
ODONTOGRAM



COMMENTS



Indicate existing teeth



Mr. Mrs.
Miss _____
Last First

Date: _____
Birth date: ☐☐ ☐☐ ☐☐
Month Day Year

Male ☐
Female ☐

Spouses name: _____

Address: _____ City: _____ Code: _____

Telephone Res. _____ Bus. _____ Refered by: _____

Physician: _____ Dentist: _____

Insurance Coverage: yes / no

Denture Status: CUD: _____ CLD: _____ PUD: _____ PLD: _____ Dental Implants: _____

Immediate Dentures: _____

Dental Insurance / Billing Information

Dental Insurance Information:

Primary Carrier	Group / Policy #	Employee ID#	Dep.	Plan % A	B	Ded.	Other
		Cert.#					

Employer: _____ Phone: _____

Insurance variance notes: _____

Spouse name: _____ Birth date: ☐☐ ☐☐ ☐☐
Month Day Year

Primary Carrier	Group / Policy #	Employee ID#	Dep.	Plan % A	B	Ded.	Other
		Cert.#					

Employer: _____ Phone: _____

Insurance variance notes: _____

Spouse name: _____ Birth date: ☐☐ ☐☐ ☐☐
Month Day Year