Lifelike Dentures

(253) 813-8000

Thank You for selecting our dental team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information ☐Male ☐Female

Name _____ Birth Date_____ SSN_____

Address _____

City_____ State_____ Zip Code _____

Home Phone_____ Cell Phone_____ Email_____

Employer _____ Work Phone_____

Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

If Student -------- Name of School_____ ☐Full Time ☐Part Time

If Married -------- Name of Spouse_____ Patient of Record? Yes/No

Whom May We Thank for Referring You?_____

Emergency Contact_____ Phone_____ Relationship_____

Responsible Party ☐Self* ☐Spouse ☐Father ☐Mother ☐Other_____

Method of Payment for Dental Treatment: ☐Cash/Check ☐Credit Card

Name_____ Birth Date_____ Home Phone_____

* (If self, proceed to Insurance Information)

Address_____ City/State/Zip Code_____

Employer_____ Work Phone_____ Cell Phone_____

Insurance Information I have: ☐Primary ☐Secondary ☐No Insurance (Self-pay)

Primary Insurance Co._____ Employer_____

Subscriber's Name_____ ID Number_____ Birth Date_____

Insurance Company's Phone_____ Group Number_____

Secondary Insurance Co. _____ Employer_____

Subscriber's Name_____ ID Number_____ Birth Date_____

Insurance Company's Phone_____ Group Number_____

Medical History

Are you currently under the care of a physician? ☐Yes ☐No Reason _____

Name of Physician _____ Phone _____ Last Exam _____

Name of Previous Dentist _____ Phone _____ Last Exam _____

Are You Taking any Medications? ☐Yes ☐No If yes, please list _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITION? Circle Yes or No

Anemia ---------- Yes/No
Arthritis, Rheumatism ---------- Yes/No
Artificial Heart Valve (Year____) ---------- Yes/No
Artificial Joints (Year____) ---------- Yes/No
Asthma ---------- Yes/No
Back/Neck Problems ---------- Yes/No
Bleeding Abnormally ---------- Yes/No
Blood Disease ---------- Yes/No
Cancer ---------- Yes/No
Chemical Dependency ---------- Yes/No
Chemotherapy ---------- Yes/No
Congenital Heart Condition ---------- Yes/No
Cough, persistent or bloody ---------- Yes/No
Diabetes (Type_____) ---------- Yes/No
Emphysema ---------- Yes/No
Epilepsy/Seizures/Fainting ---------- Yes/No
Glaucoma ---------- Yes/No
Heart Murmur ---------- Yes/No
Heart Disease/Heart Surgery ---------- Yes/No
Hepatitis (Type_____) ---------- Yes/No
High Blood Pressure ---------- Yes/No
HIV/AIDS ---------- Yes/No

Kidney Disease ---------- Yes/No
Liver Disease ---------- Yes/No
Pacemaker/Defibrillator Implant ---------- Yes/No
Psychiatric Care ---------- Yes/No
Radiation Treatment ---------- Yes/No
Respiratory/Breathing Problems ---------- Yes/No
Sinus Trouble ---------- Yes/No
Sleep Apnea ---------- Yes/No
Steroid Treatment ---------- Yes/No
Stroke ---------- Yes/No
Thyroid Problems ---------- Yes/No
TMJ ---------- Yes/No
Tuberculosis ---------- Yes/No
Tumor or Growth ---------- Yes/No
Ulcer ---------- Yes/No
Venereal Disease ---------- Yes/No
Other (please list) ---------- Yes/No

FEMALES ONLY:
Pregnant (due date_____) ---------- Yes/No
Nursing ---------- Yes/No
Taking Oral Contraceptives ---------- Yes/No

ARE YOU ALLERGIC TO OR HAVE YOU HAD <u>A REACTION TO</u> ANY OF THE FOLLOWING? Circle Yes or No

Antibiotics (e.g. Penicillin ---------- Yes/No
If yes, list

Aspirin ---------- Yes/No
Codeine ---------- Yes/No
Iodine ---------- Yes/No
Other (please list) ----------

Latex ---------- Yes/No
Local Anesthetics ---------- Yes/No
If yes, list ---------- Yes/No
Metals ---------- Yes/No
Sulfa Drugs ---------- Yes/No

_____
Date of initial placement of Denture or Partial

ADDITIONAL QUESTIONS

1) Do you use tobacco products? Yes/No
2) Are your teeth sensitive to hot or cold? Yes/No
3) Have you had orthodontic treatment? Yes/No
4) Have you taken "bisphosphonates"? Yes/No
(Fosamax, actonel, aredia, zometa, etc)

5) Do you wear dentures or partials? Yes/No
6) Do you have any dental implants? Yes/No
7) Do you like your smile? Yes/No
8) Are you interested in cosmetic dentistry? Yes/No
If yes, circle: whitening, crowns, veneers, implants, other

AUTHORIZATION AND RELEASE

The above questions have been answered accurately. I authorize Lifelike Dentures to release any necessary information to third party payers or health practitioners as needed for consultation, treatment or payment. I authorize and direct payment of the dental benefits otherwise payable directly to Lifelike Dentures. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. By signing this form, I am authorizing Lifelike Dentures to provide treatment for myself or my minor dependent.

_____ DATE _____
Signature of Patient or parent/guardian if minor