Bow Valley Denture Centre
105-104 Kananaskis Way
Canmore, Alberta T1W 2X2
Tel. 403.678.6315
Fax: 403.678.5843
Toll Free: 877.714.1777

Westside Denture Centre
202 - 1919 Sirocco Drive SW
Calgary, Alberta T3H 2Y3
Tel. 403.242.5880
Fax: 403.242.5837
Toll Free: 877.714.1777

PATIENT REGISTRATION

Full Legal Name: ____ **Date** ______________________

Gender: ○ Male ○ Female **Birth Date:** (M/D/Y) _______________________________________

Mailing Address: ____

City: __________________________ **Province:** ________________ **Postal Code:** ________________

Phone Numbers:

Home: _________________ **Cell:** __________________ **Work:** ______________________________

Email Address: ____

Emergency Contact Name: _________________________ **Phone#:** _________________________

Legal Guardian / Responsible Individual (if Applicable): ____________________________________

Occupation: ____

Physician: _______________________________ **Phone#:** ______________________________

Dentist: _________________________________ **Phone#:** ______________________________

Whom may we thank for referring you to our office: ______________________________________

Alberta Health Number: ____

Primary Dental Insurance:

Insurance Company Name: ____

Policy Holders Name: ___________________________ **D.O.B (M/D/Y):** ________________________

Relationship to Policy Holder: ____

Employer: ____

Identification#: ____________________________ **Group:** ___________________________________

Secondary Dental Insurance:

Insurance Company Name: ____

Policy Holders Name: ________________________ **D.O.B (M/D/Y):** ______________________

Relationship to Policy Holder: ____

Employer: ____

Identification#: _________________________ **Group:** _______________________________

Dental History

Current age of dentures: Upper ______ **Lower** _________ **Made by:** ______________________

Current problems with your dentures (please check):

☐ Fit ☐ Appearance ☐ Comfort ☐ Chewing ☐ Jaw pain ☐ Speech ☐ All of the above

Last dental visit? __________________ **Treatment:** _____________________________________

Problems eating your food? .... ○ Yes ○ No

If Yes, Which foods? ____

Do you wear your dentures at night? .... ○ Yes ○ No

Do you find yourself clenching or grinding your teeth? .... ○ Yes ○ No

Medical History

Are you presently in good health? .... ○ Yes ○ No

Are you under the care of physician at this time? .... ○ Yes ○ No

If yes what for? ____

Are you on any medication at this time? (Provide List) .... ○ Yes ○ No

If yes, please list: ____

Are you allergic to any medications or substances? .... ○ Yes ○ No

If yes, please list: ____

Do you smoke or use chewing tobacco? .... ○ Yes ○ No

Have you had any significant weight gain or loss lately? .... ○ Yes ○ No

If so, how much weight gained or lost? ____

Are you on a special diet? .... ○ Yes________________________ ○ No

If yes, is it .... ○ Physician Recommended? ○ Self-imposed?

Have you ever had a serious injury to your head, neck, back or mouth? ……….. ○ Yes ○ No

If yes, please specify: ____

Do you currently have or had any of the following: (please check)

☐	Aids	☐	Epilepsy	☐	Nervous disorder
☐	Anemia	☐	Facial Muscle Pain	☐	Sinus
☐	Arthritis	☐	Heart disease	☐	Stroke
☐	Bleeding Disorder	☐	Hepatitis A, B, C	☐	Thyroid disorder
☐	Cancer	☐	High blood pressure	☐	Tuberculosis
☐	Chronic dry mouth	☐	Jaw joint pain		
☐	Chronic Headache	☐	Kidney trouble		
☐	Cold sores	☐	Low blood pressure		
☐	Diabetes	☐	Mental Disorder		

Any other information not listed above we should know about: (Please list)

____

____

____

Office Policy

Payment for services are due as services are rendered. You are responsible for knowing what your insurance covers. You are also responsible for any outstanding balances owing on your account. Any other arrangements must be made prior to starting your treatment. To the best of my knowledge, all of my preceding answers are true and correct. By Signing below you have read and understand our office policy.

Patient Signature: ________________________ **Date:** ______________________________