**Forest Lawn Denture Clinic**

**#16 3012 17 Ave S.E.**

**Office Use Only**

**Medical History Alert Numbers**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental History Alert Numbers**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Calgary, Alberta T2A-0P9**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal Information: Please Print or place an “X” into the appropriate box(es)** | | | | | | | | | | | | | | | | | | | | | |
| **Date:** | | | | | | | | | | | | | | | | |  | | | | |
|  | | | | | | | | | | | | | | | | | **MM/DD/YYYY** | | | | |
| Name: | |  | | | | | | | | | | | | | | | | | | | |
|  | | Last | | | | | | First | | | | | | Second | | | | | Used | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Date of Birth | |  | | | | | | Gender: | | | | | | Female  Male | | | | |  | | |
|  | | MM/DD/YYYY | | | | | |  | | | | | |  | | | | |  | | |
| Home Address: | |  | | | | | | | | | | | | Home Phone: | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| City: | |  | | | | | |  | | | | | | Work Phone: | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Province: |  | | | | | | | | |  | | | | | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Postal Code: | |  | | | | | |  | | | | | | Cellular Phone: | | | | |  | | |
|  | |  | | | | | |  | | | | | |  | | | | |  | | |
| Home Email: | |  | | | | | | | | | |  | Work Email: | |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Physician: | |  | | | | | | | | | | | | Phone: | | | | |  | | |
|  | |  | | | | |  | | | | | | |  | | | | |  | | |
| Dentist: | |  | | | | | | | | | | | | Phone: | | | | |  | | |
|  | |  | | | | |  | | | | | | |  | | | | |  | | |
| Previous Denturist: | |  | | | | | | | | | | | | Phone: | | | | |  | | |
|  | |  | | | | |  | | | | | | |  | | | | |  | | |
| Hygienist: | |  | | | | | | | | | | | | Phone: | | | | |  | | |
|  | |  | | | | |  | | | | | | |  | | | | |  | | |
| Referred by: | |  | | | | | | | Profession/Relation: | | | | | | | Phone: | | |  | | |
|  | |  | | | | |  | | | | | | |  | | | | |  | | |
| Legal Guardian (if applicable): | | | | |  | | | | | | | | | Contact Number: | | | | |  | | |
|  | |  | | | | |  | | | | | | |  | | | | |  | | |
| In Case of Emergency, contact: | | | |  | | | | | | | | | | Contact Number: | | | | |  | | |
| Relationship: | |  | | | | | | | | | | | | Cellular Number: | | | | |  | | |
|  | |  | | | | | |  | | | | | |  | | | | |  | | |
| Your Occupation: | |  | | | | | | | | | | | | | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Your Living Environment: | | Do you require medical devices or equipment such as oxygen, walker, cane, etc? ……… | | | | | | | | | | | | | | | | | | Yes | No |
|  | | If yes, please describe: | | | |  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Your Personal Accommodation | | Private Residence | | | | Multifamily dwelling | | | | | | | | Assisted Living | | | | | Nursing Home | | |
|  | |  | | | |  | | | | | | | |  | | | | |  | | |
| Individual Responsible  For Account: | | | Patient | | | | | | | | Guardian | | | |  | | | | | | |
|  | | | Insurance & Patient | | | | | | | | Insurance & Guardian | | | | | | | | | | |
| (For insurance, complete an insurance information form) | | | | | | | | | | | | | | | | | | | | | |