Kelowna Denture Clinic
Bringing unique smiles to life

NEW PATIENT FORM

PERSONAL INFORMATION

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss

Last Name _____ First Name _____

☐ Female ☐ Male Birthdate (mm/dd/yy) _____

Spouse's Name _____

Address _____

City _____ Prov. _____ Postal Code _____

Home phone _____ Work phone _____

Cell phone _____

Referred by _____

Physician _____ Dentist _____

Denture status

☐ No Dentures

☐ Complete Upper Denture ☐ Complete Lower Denture

☐ Partial Upper Denture ☐ Partial Lower Denture

☐ Implant-Supported Upper Denture ☐ Implant-Supported Lower Denture

☐ Immediate Upper Denture ☐ Immediate Lower Denture

DENTAL INSURANCE/BILLING INFORMATION

Primary Carrier _____Group/Policy # _____

Employee ID/Certificate # _____ Dependent # _____

Spouse's name _____ Birthdate (mm/dd/yy) _____

Secondary Carrier _____Group/Policy # _____

Employee ID/Certificate # _____ Dependent # _____

Spouse's name _____ Birthdate (mm/dd/yy) _____