FAIRHAVEN DENTURE CARE
GUIDANCE | PRECISION | CONFIDENCE

Form Ref: FDC-2026-A
1132 Finnegan Way, Bellingham, WA 98225
Phone: (360) 746-8300 | info@fairhavendenture.com

PATIENT INTAKE & MEDICAL HISTORY FORM

1. PATIENT INFORMATION

Full Name (Last, First, Middle): _____ Preferred Name: _____ Date of Birth: _____

Street Address: _____ City / State / Zip: _____

Cell Phone: _____ Home / Work Phone: _____ Gender: _____

Email Address: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____ Relationship to Patient: _____

Primary Care Physician: _____ Current Dentist: _____

2. DENTAL & PROSTHETIC HISTORY

Please check all that apply to your current dental situation and goals.

☐ Never worn dentures before
☐ Wears Complete Upper Denture Age: ____ yrs
☐ Wears Complete Lower Denture Age: ____ yrs
☐ Wears Partial Denture (Upper / Lower)
☐ Has natural remaining teeth

Primary Reason for Today's Visit:

☐ New Dentures
☐ Denture Repair / Broken Tooth
☐ Reline / Loose Fit
☐ Sore Spots / Discomfort
☐ Consultation
☐ Interested in Dental Implants
Last dental visit: _____

3. MEDICAL HISTORY & HEALTH SCREENING

Denturists must evaluate systemic conditions that impact oral tissues, bone resorption, and healing.

CRITICAL MEDICAL WARNINGS - PLEASE CHECK IF APPLICABLE:

☐ Taking Blood Thinners / Anticoagulants
☐ Taking Bisphosphonates / Bone Drugs
☐ Requires Antibiotic Pre-medication

Do you have or have you ever had any of the following? (Check all that apply):

☐ High Blood Pressure
☐ Dry Mouth (Xerostomia)
☐ Diabetes (Type I/II)
☐ Hepatitis / Liver Disease
☐ Heart Disease / Attack
☐ Excessive Bleeding
☐ Stroke / TIA
☐ Epilepsy / Seizures
☐ Cancer / Chemo / Radiation
☐ Kidney Disease
☐ Asthma / Respiratory
☐ Arthritis / Joint Pain
☐ Tobacco / Vaping Use
☐ Osteoporosis / Bone Loss
☐ Pacemaker / Valve / Joint Repl.

Allergies (Check all that apply):

☐ Penicillin / Antibiotics
☐ Latex
☐ Local Anesthetics
☐ Acrylic / Plastics
☐ Sulfa Drugs
☐ Aspirin / NSAIDs
☐ Other: _____

List Current Prescription & Over-the-Counter Medications:

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OFFICE POLICIES, FINANCIAL AGREEMENT & INFORMED CONSENT

4. FINANCIAL POLICY

PAYMENT POLICY

Payment for services is rendered at the time of treatment unless prior financial arrangements have been established. We accept Cash, Debit, Visa, MasterCard, and approved Third-Party Financing. For custom prosthetics requiring multiple appointments, a 50% deposit is required at the initial impression stage, with the remaining balance due upon final delivery and insertion.

INSURANCE

While we do not bill insurance companies directly, we are pleased to provide a detailed statement complete with appropriate dental codes for you to submit independently to your insurance provider for potential reimbursement.

5. COMMUNICATION & HIPAA COMMUNICATION PREFERENCES

We may contact you regarding appointments, treatment updates, or billing matters. Please indicate your communication preferences below:

Initial here if we cannot leave a detailed voicemail: [ ]

☐ OK to send SMS appointment reminders to cell phone

6. INFORMED CONSENT FOR DENTURE & PROSTHETIC TREATMENT

NATURE OF DENTURE TREATMENT

Removable prostheses (full dentures, partial dentures, relines, and repairs) are artificial devices designed to replace missing teeth and tissue. While every effort is made to achieve optimal fit, aesthetics, and function, individual anatomical limitations (such as ridge resorption, saliva flow, and tissue sensitivity) directly affect the final outcome.

ADAPTATION PERIOD & EXPECTATIONS

New dentures require a period of physical adjustment. Speech alterations, temporary increased salivation, minor soreness, and muscle fatigue are standard during the breaking-in phase. Follow-up adjustments are included for the life of the denture if you return for annual exams and follow recommended treatment.

SCOPE OF PRACTICE ACKNOWLEDGMENT

I understand that Denturists specialize specifically in the design, construction, fitting, and repair of removable dentures. A denturist examination is focused on prosthetic suitability and soft tissue health related to prosthetics, and does not replace a comprehensive diagnostic exam by a licensed general dentist for natural teeth and complex pathology.

7. ACKNOWLEDGMENT & AUTHORIZATION SIGNATURES

I certify that I have read and understand the above information to the best of my knowledge. The questions have been accurately answered. I authorize the clinic staff to perform the necessary dental/denture services I may need, and I assume full financial responsibility for all services rendered.

Patient / Guardian Signature	**Date (MM/DD/YYYY)**
Print Patient / Guardian Name	**Relationship to Patient**