SWISS DENTURE CLINIC
"a dynamic smile . . . with style"

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 _____ MM/DD/YYYY Gender: ☐ Female ☐ Male

Home Address: _____ Home Phone: _____

City: _____ Work Phone: _____

Province: _____

Postal Code: _____ Cellular Phone: _____

Home Email: _____ Work Email: _____

* Would you like appointment reminders via ☐ Email ☐ Telephone Call

Physician: _____ Phone: _____

* Dentist: _____ Phone: _____

Previous Denturist: _____ Phone: _____

Personal Health Number _____ AISH Number: _____

* How Did You Hear About Us? _____ _____

Legal Guardian (if applicable): _____ Contact Number: _____

In Case of Emergency, contact: _____ Contact Number: _____

Relationship: _____ Cellular Number: _____

Your Occupation: _____

Primary Insurance: _____

* Subscriber: _____ Group #: _____ ID#: _____

Secondary Insurance: _____

* Subscriber: _____ Group #: _____ ID#: _____

* Spouse Date of Birth: _____