MOUTH GUARD

DATE: _____

First name: _____ **Last name:** _____ Sex: M / F

Address: _____

City, Province, Postal Code: _____

Phone: (___) ____ - _____ **E-mail address:** _____

Birth Date (DD/MM/YYYY): _____

How did you find our office? _____

Why do you need a mouthguard? _____

Preferred colour or combination of colours _____

MEDICAL / DENTAL Information

Are you presently taking any medication? YES / NO (circle)

If YES, please specify: _____

Are you currently being treated for any medical condition? YES / NO (circle)

If YES, please specify: _____

Do you have any allergies? YES / NO (if YES specify) _____

Do you have any wobbly teeth? YES / NO (circle)

Do you wear braces? YES / NO (circle)

PRIVACY POLICY / PATIENT CONSENT

I understand that **R. Kulik Denture Clinic** will only collect information needed to serve patient needs and will maintain the privacy and security of the information in accordance with its **Privacy Policy** (posted) as well as the **Personal Information Protection Act.**

I consent to the provision of a custom fitted mouthguard (which includes taking dental impressions) for:

My child / dependant _____ or myself _____

Signature (Parent / Guardian if under 16)

Office use: Colour inserted_____