PO Box 58, 7 Gretchen Lane
Standish, ME 04084
207-642-2310

Paul M. Levasseur, LD ● Shannon M. Gryskwicz, LD ● Astrid Chiasson, LD

PATIENT INFORMATION

Last Name:______________________ First Name:_______________ Middle:__________

Address:_______________________________________ City: _______________________

State: ____________________________ Zip: __________Home Phone: ______________

Work Phone: ________________________ Birth Date: ________________ Sex: M / F

Social Security Number: _________________________

Date of Extractions: _______________________ Age of Denture: ____________________

Who referred you to our practice?

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Patient Contractual Agreement

Upon entering into treatment at this practice, I the patient, understand that the services being provided to me are for denture therapy and I am not just purchasing a denture or dentures. I understand that my treatment involves not only the appliances themselves and professional expertise, but also my active participation in my own treatment. It is my understanding that compliance with the patient education I am provided, return visits and patience will be required for successful treatment. I am aware that should I choose to unduly delay or abandon my treatment, at minimum, the cost of the initial deposit of my treatment will be retained for expenses and professional time.

Patient Signature:____________________________________ Date: __________________