

Patient Information

Title _____ First Name _____ Last Name _____

Birthdate (month/date/year) _____

Address _____ Postal code _____

Insurance Company _____ policy# _____ ID# _____

Policy holder name _____ Date of birth _____

Other Insurance Company _____ policy# _____ ID# _____

Policy holder name _____ Date of birth _____

Contact Information

Cell: _____ Home: _____

Work: _____ Emergency contact info: _____

Email: _____

Is there a phone number you prefer to be contacted at? _____

Do you prefer to be reminded of your appointment by email, text or phone call? _____

Referred by / How did you hear about us? _____

Medical History

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

Do you have or have you ever had

	YES	NO		YES	NO
1. hospitalization for illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	29. glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic or bad reaction to any of the following: <input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine <input type="checkbox"/> penicillin <input type="checkbox"/> erythromycin <input type="checkbox"/> tetracycline <input type="checkbox"/> sulfa <input type="checkbox"/> local anesthetic <input type="checkbox"/> fluoride <input type="checkbox"/> metals (nickel, gold, silver, _____) <input type="checkbox"/> latex <input type="checkbox"/> nuts <input type="checkbox"/> fruit <input type="checkbox"/> other	<input type="checkbox"/>	<input type="checkbox"/>	30. contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months	<input type="checkbox"/>	<input type="checkbox"/>	31. head or neck injuries	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	32. epilepsy, convulsions (seizures)	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO)	<input type="checkbox"/>	<input type="checkbox"/>	33. neurologic disorders (ADD/ADHD, prion disease)	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	34. viral infections and cold sores	<input type="checkbox"/>	<input type="checkbox"/>
7. orthopedic implant (joint replacement)	<input type="checkbox"/>	<input type="checkbox"/>	35. any lumps or swelling in the mouth	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	36. hives, skin rash, hay fever	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	37. STI/STD/HPV	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners)	<input type="checkbox"/>	<input type="checkbox"/>	38. hepatitis (type _____)	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	39. HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
12. prolonged bleeding due to a slight cut (INR > 3.5)	<input type="checkbox"/>	<input type="checkbox"/>	40. tumor, abnormal growth	<input type="checkbox"/>	<input type="checkbox"/>
13. pneumonia, emphysema, shortness of breath, sarcoidosis	<input type="checkbox"/>	<input type="checkbox"/>	41. radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis, measles, chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	42. chemotherapy, immunosuppressive medication	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma	<input type="checkbox"/>	<input type="checkbox"/>	43. emotional difficulties	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	<input type="checkbox"/>	<input type="checkbox"/>	44. psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	45. antidepressant medication	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease	<input type="checkbox"/>	<input type="checkbox"/>	46. alcohol/recreational drug use	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid, parathyroid disease, or calcium deficiency	<input type="checkbox"/>	<input type="checkbox"/>	47. presently being treated for any other illness	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency	<input type="checkbox"/>	<input type="checkbox"/>	48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol or taking statin drugs	<input type="checkbox"/>	<input type="checkbox"/>	49. taking medication for weight management	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes (HbA1c =)	<input type="checkbox"/>	<input type="checkbox"/>	50. taking dietary supplements	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	51. often exhausted or fatigued	<input type="checkbox"/>	<input type="checkbox"/>
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia)	<input type="checkbox"/>	<input type="checkbox"/>	52. experiencing frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)	<input type="checkbox"/>	<input type="checkbox"/>	53. a smoker, smoked previously or use smokeless tobacco	<input type="checkbox"/>	<input type="checkbox"/>
27. arthritis	<input type="checkbox"/>	<input type="checkbox"/>	54. considered a touchy/sensitive person	<input type="checkbox"/>	<input type="checkbox"/>
28. autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma)	<input type="checkbox"/>	<input type="checkbox"/>	55. often unhappy or depressed	<input type="checkbox"/>	<input type="checkbox"/>
			56. taking birth control pills	<input type="checkbox"/>	<input type="checkbox"/>
			57. currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>
			58. diagnosed with a prostate disorder	<input type="checkbox"/>	<input type="checkbox"/>

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment.(i.e. Botox, Collagen Injections)_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____

Doctor's Signature _____

Dental History

Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam _____ Date of most recent x-rays _____

Date of most recent treatment (other than a cleaning) _____

I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

Personal History

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had an unfavorable dental experience? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had complications from past dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had trouble getting numb or had any reactions to local anesthetic? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? | <input type="checkbox"/> | <input type="checkbox"/> |

Gum And Bone

- | | Yes | No |
|---|--------------------------|--------------------------|
| 7. Do your gums bleed or are they painful when brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever noticed an unpleasant taste or odor in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Is there anyone with a history of periodontal disease in your family? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever experienced gum recession? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |

Tooth Structure

- | | Yes | No |
|--|--------------------------|--------------------------|
| 14. Have you had any cavities within the past 3 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have grooves or notches on your teeth near the gum line? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you frequently get food caught between any teeth? | <input type="checkbox"/> | <input type="checkbox"/> |

Bite And Jaw Joint

- | | Yes | No |
|--|--------------------------|--------------------------|
| 21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Are your teeth becoming more crooked, crowded, or overlapped? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Are your teeth developing spaces or becoming more loose? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you place your tongue between your teeth or close your teeth against your tongue? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you clench or grind your teeth together in the daytime or make them sore? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Do you wear or have you ever worn a bite appliance? | <input type="checkbox"/> | <input type="checkbox"/> |

Smile Characteristics

- | | | |
|--|--------------------------|--------------------------|
| 33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you ever whitened (bleached) your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you felt uncomfortable or self conscious about the appearance of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you been disappointed with the appearance of previous dental work? | <input type="checkbox"/> | <input type="checkbox"/> |

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Consent To Dental Photography

I, _____ (Patient), authorize Aqua Dental Wellness, to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment. I consent to allow the photographs to be used for the following:

- Dental Records
- Dental Research
- Dental Education including lectures, seminars, demonstrations, professional publications
such as journals or books
- Marketing material, including websites and printed materials, patient education

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

Check here if you do not want your full face shot used for any of the above purposes

Signature (Patient) _____ Date _____

Patient Financial Responsibility

I, _____, understand that I am financially responsible for any and all fees incurred during my dental treatment if they are not covered by my dental insurance. I understand that my dental insurance has certain limitations and restrictions, such as authorization requirements, waiting periods, as well as non-covered services. I agree to pay all outstanding fees at the time they are presented to me upon check out.

Signature of person financially responsible for account

Date