AQUA DENTISTRY
Total Patient Care

Name:______________________ SS#__________ Date:________
Address:______________________ City:__________ Zip: ________
Home Phone:__________ Business Phone: __________ Cell: __________
Occupation:______________ Sex: ☐ M ☐ F Age:_____ DOB:__________
Who may we thank for referring you? ______________________
E-Mail Address: ______________

Dental Insurance

Insured First Name: ____________ Last Name: __________ DOB:________
Insured Address: ______________________
Patient relationship to Insured (Circle): Self Spouse Child Parent Sex: (M) (F) Insured's SSN: __________
Employer______________ Employer's Phone Number __________
Insurance Co.: ______________ Insurance Co. Address: __________
Group #: ______________ Policy #: ______________ Effective Date ________
Phone Number of Insurance Co.: ______________
Name of Union and Local Union Number______________________

Secondary Insurance

Insured First Name: ____________ Last Name: __________ DOB:________
Insured Address: ______________________
Patient relationship to Insured (Circle): Self Spouse Child Parent Sex: (M) (F) Insured's SSN: __________
Employer______________ Employer's Phone Number __________
Insurance Co.: ______________ Insurance Co. Address: __________
Group #: ______________ Policy #: ______________ Effective Date ________
Phone Number of Insurance Co.: ______________
Name of Union and Local Union Number______________________

Dental History

Previous Dentist's Name: ______________________ Date of last exam: __________
Address: ______________ City:______________ Zip:________ Phone: __________
Date of last dental X-rays: ______________ ☐Bitewings ☐Full Mouth X-ray ☐Panographic X-ray
How often do you brush per day? ________ How often do you floss per day? ______ Last teeth cleaning:________
Have you had problems with prior dental treatment? ☐ Yes ☐No
Have you had problems with dental anesthesia? ☐Yes ☐ No
Reason for today's visit: ______________________

Check any of the following conditions that apply to you:

☐Bad breath
☐Bleeding Gums
☐Clicking or popping jaw
☐Cold sores
☐Food collection between teeth
☐Grinding teeth
☐Jaw Pain
☐Loose teeth or broken fillings
☐Oral Surgery
☐Orthodontics
☐Periodontal/gum surgery
☐ Root canal
☐ Sensitivity to cold
☐ Sensitivity to heat
☐ Sensitivity to sweets
☐ Sensitivity when biting
☐Sores or growth in your mouth
☐Teeth Extracted

List any vitamins, minerals or herbal products that you take: ______________________
Have you ever taken any of these diet medications? ☐ Dexfenfluramine ☐ Fen-phen ☐ Pondimin ☐ Redux
Do you smoke/chew tobacco products? ☐ No ☐ Yes, How often? ______________________
Do you use recreational drugs? ☐ No ☐ Yes, What kind? ______________ How often? __________
Do you drink alcohol? ☐ No ☐ Yes, How often? ______________

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Medical History

Name:________________________

Your Primary Physician's Name:____________________________ Date of last physical exam: ________________

Address: ____City:__________________ Zip: ____________

Phone:________________Is more than one doctor treating you? ☐ Yes ☐ No For What?____________________

Doctor's Name:___________________________ Address: ____

City:________________________ State:_____ Zip:______________ Phone:______________________________

List all medications you are currently taking: ____

In case of emergency notify: ________________________ **Relationship:** ______________________

Phone:_____________

Have you ever had an adverse reaction to any of the following?

☐Penicillin or other antibiotics ☐Aspirin, Codeine or other pain medications ☐Novocain, Lidocaine, or other anesthetics ☐ Latex ☐ Other____

Have you been hospitalized, had a serious illness, or had any kind of surgery in the past 5 years? Yes ☐ No ☐

If yes, what for ______________________**Women**: Are you pregnant? Yes ☐ No☐ Nursing? Yes ☐ No☐

Taking oral contraception? Yes ☐ No ☐

Check any of the following that apply to you:

☐ AIDS
☐ Alcoholism
☐ Allergies _____________
☐ Anemia
☐ Angina/Chest Pain
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Back Problems
☐ Bleeding Abnormally
☐ Blood Disease
☐ Blood transfusions
☐ Blurred vision
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Congenital Heart Defect
☐ Contact lenses
☐ Diabetes
☐ Difficulty swallowing
☐ Difficulty urinating, blood in urine
☐ Dry mouth
☐ Emphysema
☐ Epilepsy
☐ Excessive thirst/urination
☐ Fainting
☐ Frequent vomiting, nausea
☐ Frequent urination
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
Describe ___________
☐ Hemophilia
☐ Hepatitis
☐ Hernia Repair
☐ Herpes
☐ High Blood Pressure
☐ HIV positive
☐ Jaundice
☐ Joint pain, stiffness
☐ Joint Surgery
When? ___________
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Nervous Problems
☐ Pacemaker
☐ Persistent cough, coughing up blood
☐ Prolonged Bleeding
☐ Psychiatric Care
☐ Radiation Treatment
☐ Recent weight loss, fever, night sweats
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Sexually Transmitted Diseases
☐ Shortness of breath
☐ Skin Rashes
☐ Stroke
☐ Swelling of feet or ankles
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors
☐ Ulcer
☐ Other
Describe_____________

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Office use only: Pulse__________ Blood Pressure _________Weight(Optional) __________

Family History: Please check the current status of your immediate family members:
Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

☐Alcoholism
☐High cholesterol
☐Cancer
Type:___________________
☐High blood pressure

☐Heart disease
☐Stroke
☐Depression/suicide
☐ Bleeding or clotting disorder

☐ Asthma/COPD
☐Diabetes
☐Other:_________________

I request that all dental benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the provider of service. I understand that I am financially responsible for all charges for services performed by provider. If insurance proceeds are insufficient to cover my obligations for services rendered, I am liable for the shortfall. I authorize the provider of service to release all information necessary to secure the payment of benefits. I also consent to the examination and/or treatment of myself and all minor children listed by doctors, doctor's assistants and other medical personnel. Failure to provide complete information may result in my receiving a bill for services.
I am aware that by signing below I certify that all information is complete and correct. Aqua Dentistry may verify this information.

Responsible Party Signature: ____________________________________ Date: _________________

Drs. Signature: ____ Date: __________________

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