

 **AQUILA DENTAL**
NEW PATIENT INFORMATION FORM

Patient Information:

Patient Name _____

By what name do you prefer to be called? _____

Birthday: _____ Social Security No: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name of Employer: _____

If full time student, name of school: _____

Name of person responsible for account: _____

Address/Phone (if different from above): _____

E-Mail Address: _____

Name of Spouse: _____ Spouse's Employer _____

Emergency Contact Person: _____ Relationship _____ Phone: _____

How did you hear about our office? _____

Insurance Information

First Insurance Company : _____ Employer: _____

Subscriber Name: _____ Birthdate: _____ Social Security#: _____

Group # /Policy #: _____ Effective Date: _____

Relationship to Patient _____ Self: _____ Spouse: _____ Child: _____ Other: _____

Second Insurance Company : _____ Employer: _____

Subscriber Name: _____ Birthdate: _____ Social Security#: _____

Group # /Policy #: _____ Effective Date: _____

Relationship to Patient _____ Self: _____ Spouse: _____ Child: _____ Other: _____

CONSENT

I acknowledge that all the information is accurate to the best of my knowledge. I hereby authorize Aquila Family & cosmetic Dentistry and/or their trained staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize Aquila Family & Cosmetic Dentistry and/or their trained staff to perform any and all forms of treatment, Medications and therapy, That may be indicated. I also understand the use of anesthetic agents will be used when indicated and that this embodies a certain risk. I hereby give my permission to release any medical/dental information which may be indicated to process insurance claim forms or to receive proper treatment from other health specialists.

Signature of patient/parent or Guardian _____ Date _____

 **AQUILA DENTAL**
PATIENT MEDICAL HISTORY

Patient Name _____

Date of Birth _____

Family Physician _____ Physician Phone # _____

Last physical exam _____ your current physical health is: Good ___ Fair ___ Poor ___

Medications you are currently taking: _____

Women: Are you currently pregnant, trying to get pregnant? Yes ___ No ___

Are you nursing? Yes ___ No ___, Taking contraceptives? Yes ___ No ___

CIRCLE any of the following medications you are allergic to or that have caused reactions

Aspirin	Local anesthetic (novacain)	Valium	Other _____
Nitrious Oxide	Codeine	Penicillin	_____
Percodan	Erythomycin	Sulfa	_____

Please CIRCLE any of the following conditions you have or have had in the past:

Heart Failure	Drug Addiction	Tuberculosis
Heart Disease or Attack	Stroke	Asthma
Angina Pectorus	Artificial Joints/Limbs	Hay Fever
Congenital Heart Disease	Kidney Disease/Dialysis	Allergies/Hives
Heart Murmur	Epilepsy or Seizures	Sinus Trouble
Mitral Valve Prolapse	Ulcers	Radiation Therapy
High/Low Blood Pressure	Colitis	Chemotherapy
Arteriosclerosis	Diabetes	Hepatitis A (infectious)
Pacemaker	Thyroid Problems	Hepatitis B (serum)
Heart Surgery	Bruise Easily	Hepatitis C
Arthritis	Bleeding Disorder	Liver Disease
Nervousness	Cancer	Venereal Diseases
Fainting/Dizzy spells	Emphysema	AIDS/HIV
Sub-bacterial Endocarditis	Chronic Cough	Herpes
Rheumatic/Scarlet Fever	Blood Transfusion	Hemophilia
Eye Disease/Glaucoma	Anemia	Phen-Fen
Cortisone Medication	Metal/Latex Allergies	Transplant

Y__ N__ Have you ever taken cortisone or other steroid medications?

Y__ N__ Dose Your physician require you to premedicate for dental appointments?

Y__ N__ Do You use tobacco? If so how much? _____

Y__ N__ Do you drink alcohol? If so how much? _____

Y__ N__ History of drug or alcohol abuse?

Signature of Patient/Parent or Guardian _____ Date _____

Signature of Doctor _____ Date _____

 **AQUILA DENTAL**
DENTAL HISTORY and SMILE EVALUATION

Name _____ Date _____
 Last Dental Visit _____ Reason for today's visit _____
 Has fear/discomfort kept you from regular visits? Yes _____ No _____
 Have you ever been medicated for dental treatment? Yes _____ No _____
 How do you describe your dental health? Good _____ Fair _____ Poor _____
 Home care: Brush? Yes _____ No _____ Floss? Yes _____ No _____ Other? _____
 Have you had any unusual effect from previous dental treatment? Yes _____ No _____
 Please describe _____

Have you ever had any of the following? A check indicates a YES

- | | | |
|---|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Gums bleeding | <input type="checkbox"/> Periodontal gum treatment |
| <input type="checkbox"/> Bite lips or cheek regularly | <input type="checkbox"/> Gums swollen or tender | <input type="checkbox"/> Sensitivity to hot or cold |
| <input type="checkbox"/> Blisters on lips or mouth | <input type="checkbox"/> Jaw pain or tiredness | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Swelling | <input type="checkbox"/> Food collection between teeth |
| <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Grinding/Clenching teeth |
| <input type="checkbox"/> Pain around ear | <input type="checkbox"/> Unusual lumps | |

Do you like the appearance of your teeth; your smile? YES NO
 If not, explain _____

Are your teeth in alignment (straight)? YES NO
 If not, explain _____

Do you have spaces that you do not like? YES NO
 If yes, explain _____

Do you like the color of your teeth? YES NO
 If not, explain _____

Do you like the shape of your teeth? YES NO
 If not, explain _____

Are your teeth wearing on the biting surfaces? YES NO
 If yes, explain _____

Are there old fillings or dental work you don't like looking at? YES NO
 If yes, explain _____

Are your teeth chipped? Yes _____ No _____ Protruding? Yes _____ No _____ Hidden? Yes _____ No _____
 What would you like to change the most in the appearance of your teeth? _____

How would you like your teeth to look? _____