WELCOME

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 ant 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 herby 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____________

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__ Does 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

Patient Name:____Date:____________________________

Your answers to this questionnaire will help us understand what is important to you, so that we may more effectively treat you with consideration for your specific needs and desires.

Are any of your teeth sensitive to:

Hot or Cold?	Y	N
Biting or chewing?	Y	N
Have you notice mouth odors or bad tastes?	Y	N
Do you frequently get cold sores, blisters or any other oral lesions?	Y	N
Do your gums bleed or hurt?	Y	N
Have your parents experienced gum disease or tooth loss?	Y	N
Have you noticed any loose teeth or change in your bite?	Y	N
Does food get caught between your teeth?	Y	N

Do you:

Clench or grind your teeth while awake or asleep?	Y	N
Bite your lips or cheeks regularly?	Y	N
Mouth breathe while awake or asleep?	Y	N
Have tired jaws, especially in the morning?	Y	N
Smoke or chew tobacco?	Y	N
Feel nervous about having dental treatment?	Y	N

Have you ever had:

Orthodontic treatment	Y	N
Oral Surgery	Y	N
Periodontal treatment	Y	N
Your bite adjusted?	Y	N

Have you experienced:

Clicking or popping of the jaw?	Y	N
Difficulty in opening or closing your mouth?	Y	N
Headaches or neck pain?	Y	N

How often do you brush your teeth?

______________ Floss______________

What other dental aids do you use? (Sonicare, Waterpick, toothpicks, etc.)

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Have you ever had a less than positive dental experience? Y N

If you could easily and safely whiten your teeth, would you be interested? Y N

What would you like to change the most in the appearance of your teeth?

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