# Welcome to Aqua Dental

**Patient Profile:**

First Name: _____Last Name: _____ Preferred Name: _____
Address: _____City: _____Province: _____Postal Code: _____
Home# _____Work# _____Ext# _____Cell:#_____
Email: _____ Preferred method of contact: O Phone / O email / O text
Date of Birth: _____ Age: _____Gender: _____
Partner Name and Contacts: _____Physician Name and Contacts: _____
Occupation: _____Employer: _____

**Insurance Information**

**Primary Insurance**
Name of Policy Holder: _____Policy Holder's Date of Birth: _____
Insurance company: _____ Policy/Group #: _____ ID/Certificate #: _____

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**Secondary Insurance**
Name of Policy Holder: _____Policy Holder's Date of Birth: _____
Insurance company: _____Policy/Group #: _____ID/Certificate #: _____

**Direct Billing to insurance**

We are happy to offer you direct billing to your insurance. This allows us to send your dental claims electronically on your behalf and **accept payment from the insurance** company. To have access to this service, we kindly ask you provide us with a **credit card number** (Visa/Mastercard) to be left on file to collect any **remaining balance** for yourself upon receiving the insurance cheque. **Secondary insurance** must be submitted manually which we will also assist you with processing. We strongly encourage you to learn and keep track of the details of your coverage. This includes **annual maximums and frequencies.** You are still responsible for payment should a procedure **not be covered** by your insurance.

**O Yes, I would like this service O No, I will pay and receive the insurance payment myself**

**Signature_____ Date_____**

**Cancellation Policy**

We require **48 business hours' notice** in the event that you need to reschedule your appointment. This can either be done via telephone or email. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee **starting at $50.00** will be applied to your account which is based on the length of time reserved for you or any individual family members. In addition, if you are **more than 20 minutes late** for an appointment, this is also considered a missed appointment. No further appointments will be scheduled nor can any records be transferred without the payment of this fee.

**O I understand and will comply with the policy**

**Signature _____Date_____**

When were your last dental x-rays? _____
Dental Anxiety: O None / O Mild / O Moderate / O Severe /O I'm freaking out right now ☺
Do you have any of the following?

| | | | | |
|---|---|---|---|---|
| Frequent headaches | | Bad breath/taste | | What v… your sm… |
| Grinding/clenching habits | | Bleeding gums | | |
| Jaw pain | | Loose teeth | | _____ |
| Sensitivity to hot/cold | | Food collection between teeth | | _____ |
| Sensitivity during dental cleaning | | Tooth Aches | | _____ |

**Current home care routine**
Brush: _____ /daily
Flossing: _____/Weekly
Other: _____

Additional Comments: _____
_____

# Medical History

Although dental personnel primarily treat the area in and around your mouth; your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. This information is always kept confidential as per our privacy policy. Thank you for answering the following questions

Have you ever been hospitalized, treated or had major surgery? O Yes O No If yes, please explain: _____

Have you ever had a serious head or neck injury? O Yes O No If yes, please explain: _____

Have you ever taken medication for osteoporosis? O Yes O No If yes, please explain: _____

Have you ever had a surgery to replace a valve in your heart or a total joint replaced? O Yes O No If yes, please explain: _____

Are you taking any medication or supplements? O Yes O No List: _____

How is your blood sugar level? O Normal O Borderline O High How is your blood pressure O Normal O Borderline O High

**Tobacco Use:**

Do you currently use tobacco? O If yes, How much daily/weekly? _____

Are your habits on/off? O If yes, please explain: _____

Have you ever used tobacco O If yes, How long ago? _____

Do you have future plans to quit? O Please explain: _____

**Allergies**

| | | | |
|---|---|---|---|
| Aspirin | O | Seasonal | O |
| Penicillin | O | Peanuts/nuts | O |
| Codeine | O | Other foods | O |
| Sulfa | O | Metal | O |

| Digestive system: | O | Blood conditions: | O | Bones/Joints: | O | Neurological/Psychological: | O |
|---|---|---|---|---|---|---|---|
| Acid Reflux | O | Anaemia | O | Arthritis | O | Depression | O |
| Celiac | O | Sickle cell anemia | O | Artificial Joint | O | Anxiety | O |
| Stomach ulcers | O | Stroke | O | Gout | O | Alzheimer's | O |
| Hepatitis A or B | O | Blood Transfusion | O | Osteoporosis | O | Autism | O |
| Hepatitis C | O | Bruise easily | O | Swollen joints | O | Clinical psychiatric treatment. | O |
| Liver disease | O | Excessive Bleeding | O | Inflammatory rheumatism | O | PTSD | O |
| Jaundice | O | Blood clotting | O | Sensory/Physical: | O | Seizures/epilepsy | O |
| Kidney disease | O | Leukaemia | O | Hearing impairment | O | Frequent headaches | O |
| Heart conditions: | O | Slow healing | O | Glaucoma | O | Addiction (drug/alcohol) | O |
| Chest Pains | O | Breathing: | O | Sight impairment | O | History of Growths or Cancer | O |
| Artificial Heart Valve | O | Shortness of breath | O | Cerebral Palsy | O | Type of Cancer: | O |
| Angina | O | Frequent/persistent cough | O | Paralysis | O | Radiation | O |

- Have you ever had any serious illness not listed above? O **Yes** O **No** If yes, please explain _____
- Are you on a special diet? O **Yes** O **No** If yes, please explain _____
- Do you snore or suffer from sleep apnea? O **Yes** O **No** If yes, please explain

Additional Information:

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health and the health of others. It is my responsibility to inform the dental office of any changes in medical status.

**SIGNATURE OF PATIENT, PARENT, OR GUARDIAN** _____ **DATE** _____