AQUA DENTAL WELLNESS

New Patient Form

Unit 3-1565, Regent Avenue West • Winnipeg, MB R2C 3B3 • (204) 663-3423

Patient Information

Title_____ First Name _____ Last Name _____

Birthdate (month/date/year) _____Pronouns_____

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 (Name)_____How did you hear about us? _____

AQUA DENTAL WELLNESS

NEW PATIENT DENTAL HISTORY

Patient Name:_____

How did you hear about us? _____ Referred by: (Name of friend)_____

Previous Dentist: _____ Date of most recent exam/x-rays/cleaning _____

Estimate of oral health (**please circle**): Excellent Good Fair Poor

I routinely see my dentist every **(please check)** 3Mo ○ 4Mo ○ 6Mo ○ 9Mo ○ 12Mo ○ Not Routinely ○

	Y	N
PERSONAL DENTAL HISTORY		
1. Are you fearful of dental treatment? If yes, how fearful on a scale of 1 (Least) to 10 (Very Nervous) _____	○	○
2. Have you had an unfavourable dental experience or complications with dental treatment? If yes, please describe: _____	○	○
3. Have you ever had any trouble with getting numb (ie – freezing) or local anesthetic?	○	○
4. Have you ever had braces, orthodontic treatment, or had your bite adjusted? If yes, at what age and what was the treatment? _____	○	○
5. Have you had any teeth removed or have any missing teeth?	○	○
GUM AND BONE HEALTH		
1. Do your gums bleed or are they painful when brushing/flossing?	○	○
2. Have you been diagnosed with or treated for gum disease or gum recession?	○	○
3. Do you notice any unpleasant odours, burning or painful sensations, or loose teeth?	○	○
TOOTH STRUCTURE		
1. Have you had any cavities in the last 3 years?	○	○
2. Do you feel or notice any holes or pits on the biting surfaces of your teeth or grooves and notches along the gumline?	○	○
3. Are any teeth sensitive to hot, cold, sweets, or biting? If yes, for how long ago did you notice this? _____	○	○
4. Have you broken or chipped any teeth or fillings in the last two years?	○	○
BITE AND JAW JOINT		
1. Do you have any problems with your jaw joint? If yes, please check all that apply: pain ○ sounds ○ limited opening ○ locking ○ popping ○ pressure ○ difficulty chewing hard foods ○	○	○
2. In the past 5 years, have your teeth changed? If yes, please check all that apply: Worn down teeth ○ Teeth are becoming thinner ○ Teeth are becoming crowded/overlapped ○ Teeth are developing spaces ○	○	○
3. Do you have any problems with sleep (restlessness, tooth grinding, waking up with headaches in the morning)? If yes, have you ever worn a nightguard appliance? Yes ○ No ○	○	○
SMILE CHARACTERISTICS		
1. Is there anything about the appearance of your teeth you would like to change?	○	○
2. Do you currently use any whitening products? If yes, please check all that apply: Toothpaste ○ Mouth Rinse ○ OTC products ○ Professional Whitening ○	○	○

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NEW PATIENT MEDICAL HISTORY FORM

Patient Name _____ **Preferred Name** _____ **Patient Age** ____

Name of Physician _____ Date of most recent physical exam _____

Estimate of general health (**please circle**) Excellent Good Fair Poor

	Y	N		Y	N
1. Hospitalization for illness or injury? If so, when and what for? _____ _____	◯	◯	18. Autoimmune disease (Rheumatoid Arthritis, Lupus, Scleroderma Multiple Sclerosis)?	◯	◯
2. Allergies or bad reactions to any of the following (**PLEASE CIRCLE**): Aspirin, Ibuprofen, Acetaminophen, Codeine, Penicillin, Erythromycin, Tetracycline, Sulfa, Local anesthetic, Fluoride, Metals (Silver, Nickle, Gold), Latex Other: _____	◯	◯	19. Digestive or eating disorder (celiac disease, gastric reflux, bulimia, anorexia)?	◯	◯
			20. Hives, Skin rash, Hay fever?	◯	◯
			21. Neurological Disease (Fibromyalgia, Alzheimer's Disease, Bell's Palsy)?	◯	◯
			22. Glaucoma, Cataracts, Diabetes-related Retinopathy?	◯	◯
3. Heart problems? (Cardiac stent, infective endocarditis, artificial heart valve, pacemaker or defibrillator, repaired defect)	◯	◯	23. Head or Neck injuries? Please describe: _____	◯	◯
			24. Viral infections or cold sores?	◯	◯
4. History of stroke or Myocardial infarction (Heart Attack)?	◯	◯	25. Epilepsy, Convulsions (Seizures), prone to Fainting?	◯	◯
5. Orthopedic implant (Joint replacement) Do you require pre-medication for dental treatment?	◯	◯	26. Any lumps, Bumps, Swelling, Tumors, or Abnormal growths in the mouth you've noticed?	◯	◯
6. Rheumatic or scarlet fever?	◯	◯	27. STI, HPV, HIV/AIDS, Hepatitis (Type __)?	◯	◯
7. High or Low blood pressure?	◯	◯	28. Alcohol or Recreational drug use?	◯	◯
8. Are you currently taking blood thinners? If so, what kind? _____	◯	◯	29. Neurologic or mental health disorders (ADHD, Depression, Anxiety, Autism)?	◯	◯
9. Asthma, pneumonia, emphysema, shortness of breath, or sarcoidosis?	◯	◯	30. Radiation, Chemotherapy, or immunosuppressive medications?	◯	◯
10. Tuberculosis, Measles, Chicken pox?	◯	◯	31. Diagnosed with a prostate disorder?	◯	◯
11. Breathing or sinus problems (sleep apnea, snoring, sinus issues) C-PAP?	◯	◯	32. Taking medication for weight management or dietary supplements?	◯	◯
12. Kidney or Liver disease, Jaundice?	◯	◯	33. Often exhausted, fatigued, or experiencing frequent headaches?	◯	◯
13. Thyroid or Parathyroid Disease?	◯	◯			
14. Hormone or Mineral Deficiency?	◯	◯	34. Taking birth control?	◯	◯
15. High Cholesterol or taking statin drugs?	◯	◯	35. Currently pregnant?	◯	◯
16. Diabetes (Type _____)?	◯	◯	36. Using any Tobacco, Cannabis, or Vape products?	◯	◯
17. Stomach or Duodenal ulcer?	◯	◯			

Please list all current medications, supplements, and/or vitamins:

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

PATIENT'S SIGNATURE: _____ DATE:_____

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Consent Form

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 _____

AQUA DENTAL WELLNESS

Patient Financial Responsibility Form

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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