aqua Dental Studio

2123 N University Dr. Coral Springs FL 33071

NEW PATIENT REGISTRATION FORM

DATE: _____

Patient Personal Information					
Title		Birth Date		Age	
Last, First		Marital Status		Sex	
Address		Home #			
		Cell #			
City, State, Zip		Driver Lic.			
Email		SSN			
School Name		Referral Type			
Emergency Contact		Emergency Phone #			

Patient responsible/guarantor for paying the bills					
Title		Birth Date		Age	
Last, First		Marital Status		Sex	
Address		Home #			
		Cell #			
City, State, Zip		Driver Lic.			
Email		SSN			

Do you have Primary Dental Insurance? ____ Yes ____ No			
Group No/Name			
Insurance Name			
Phone #			
Employer Name			
Subscriber Last, First		Birth Date	
Subscriber Address		Relationship to Patient	
City, State, Zip		Subscriber ID	

Patient Medical Information

Allergic to		
☐ Y ☐ N Any Know Allergies	☐ Y ☐ N Epinephrine	☐ Y ☐ N Metal or Plastic
☐ Y ☐ N Amoxicillin	☐ Y ☐ N Erythromycin	☐ Y ☐ N NSAID (Advil/Motrin)
☐ Y ☐ N Antibiotics	☐ Y ☐ N Food Allergy	☐ Y ☐ N Penicillin
☐ Y ☐ N Aspirin	☐ Y ☐ N Gluten	☐ Y ☐ N Seasonal Allergies
☐ Y ☐ N Bactrim	☐ Y ☐ N Household Bleach	☐ Y ☐ N Sulfa Drugs
☐ Y ☐ N Barbiturates/Sleeping Pills	☐ Y ☐ N Ibuprofen	☐ Y ☐ N Tetracycline
☐ Y ☐ N Clindamycin	☐ Y ☐ N Iodine	☐ Y ☐ N Valium
☐ Y ☐ N Codeine/Other Narcotics	☐ Y ☐ N Latex Rubber	☐ Y ☐ N Other:_____
☐ Y ☐ N Enviromental Allergies	☐ Y ☐ N local Anesthetics	

Check if Relevant, Past/Present

- ☐ Y ☐ N Changes since last visit
- ☐ Y ☐ N Abnormal Bleeding
- ☐ Y ☐ N Acid Reflux
- ☐ Y ☐ N ADHD/ADD
- ☐ Y ☐ N AIDS/HIV Infection
- ☐ Y ☐ N Alcohol/Drug Abuse
- ☐ Y ☐ N Alzheimer
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Angina
- ☐ Y ☐ N Ankles Swell
- ☐ Y ☐ N Anorexia
- ☐ Y ☐ N Arteriosclerosis
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Arthritis Rheumatoid
- ☐ Y ☐ N Aspirin Daily
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Autoimmune Disease
- ☐ Y ☐ N Bells Palsy
- ☐ Y ☐ N Bladder Trouble
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Blood Pressure - High
- ☐ Y ☐ N Blood Pressure - Low
- ☐ Y ☐ N Blood Sugar - Low
- ☐ Y ☐ N Blood Thinners
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bronchitis
- ☐ Y ☐ N Bulimia
- ☐ Y ☐ N Cancer/Tumor or Growth
- ☐ Y ☐ N Cardiovascular Disease
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Chest Pain Upon Exertion
- ☐ Y ☐ N Chicken Pox
- ☐ Y ☐ N Cholesterol - High
- ☐ Y ☐ N Chronic Pain
- ☐ Y ☐ N Claustrophobia
- ☐ Y ☐ N Congenital Heart Defect
- ☐ Y ☐ N Congestive Heart Failure
- ☐ Y ☐ N Contact Lenses
- ☐ Y ☐ N Damaged/Artificial Heart Valve
- ☐ Y ☐ N Damaged/Valves in Transplanted
- ☐ Y ☐ N Diabetes Type 1
- ☐ Y ☐ N Diabetes Type 2
- ☐ Y ☐ N Difficulty Breathing
- ☐ Y ☐ N Difficulty Healing
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Epilepsy
- ☐ Y ☐ N Fever Blisters
- ☐ Y ☐ N Fibromyalgia
- ☐ Y ☐ N Frequent Dry Mouth
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Gastrointestinal Disease
- ☐ Y ☐ N Gerd (Reflux) Heartburn
- ☐ Y ☐ N Glaucoma
- ☐ Y ☐ N Handicap/Disabilities
- ☐ Y ☐ N Head Injury
- ☐ Y ☐ N Hearing Impairment
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Hemophilia
- ☐ Y ☐ N Hepatitis A
- ☐ Y ☐ N Hepatitis B
- ☐ Y ☐ N Hepatitis C
- ☐ Y ☐ N Herpes
- ☐ Y ☐ N Infections - Recurrent
- ☐ Y ☐ N Infections - Throat
- ☐ Y ☐ N Jaundice
- ☐ Y ☐ N Joint Replacement Surgery
- ☐ Y ☐ N Kidney Problems
- ☐ Y ☐ N Leukemia
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Lupus
- ☐ Y ☐ N Malnutrition
- ☐ Y ☐ N Mental Health Problems
- ☐ Y ☐ N Metal Pins/Plates
- ☐ Y ☐ N Migraines
- ☐ Y ☐ N Mitral Valve Prolapse
- ☐ Y ☐ N Mouth Ulcer
- ☐ Y ☐ N Neurological Disorders
- ☐ Y ☐ N Night Sweats
- ☐ Y ☐ N Organ Transplant
- ☐ Y ☐ N Osteoporosis
- ☐ Y ☐ N Pacemaker
- ☐ Y ☐ N Previos Endocarditis
- ☐ Y ☐ N Psychiatric/Emotional Issues
- ☐ Y ☐ N Radiation Treatment
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Seizure
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shingles
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Skin Rash
- ☐ Y ☐ N Sleep Disorders
- ☐ Y ☐ N Snoring
- ☐ Y ☐ N Stomach Ulcers/Colitis
- ☐ Y ☐ N Stroke TIA
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N TMJ Problems
- ☐ Y ☐ N Tobaco Habits
- ☐ Y ☐ N Tuberculosis

Taking/Taken or Treated with

- ☐ Y ☐ N Actonel
- ☐ Y ☐ N Aredia
- ☐ Y ☐ N Biphosphates
- ☐ Y ☐ N Fen-Phen (Diet Drug)
- ☐ Y ☐ N Fosamax
- ☐ Y ☐ N Zometa

For Women Only

- ☐ Y ☐ N Birth Control
- ☐ Y ☐ N Hormone Replacement
- ☐ Y ☐ N Nursing

Additional Comments

Medical Questionnarie	
Physician's Name	
Office Address	
Office Telephone	
Has there been a recent change to the patient's health, including any hospitalizations or Illnesses?	
Is the patient currently taking any prescriptions, OTC meds, supplements, or recreational drugs?	
List Medications:	
Pharmacy Name	Phone #
Address	
Has the patient been treated now or in the past with Bisphosphonates for Osteoporosis or Cancer?	

Explain:	
Do you smoke, Vape, or chew tobacco? Please list	
How Many packs per day/often and for how long?	
Any Disease, condition or problem not listed? Please list.	
Do you have or had any heart stent in the past? When? How many?	

By Signing below, I certify that all of the above information is true to the best of my knowledge

Patient/Guardian Signature	Date
Dentist Signature	Date