PATIENT INFORMATION (Confidential)

Name ______________________________ Birth date ______________

Address ______________ City ______________ Prov __________ Postal Code __________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Employer ______________________________ Marital Status ______________

E-mail ______________________________ Gender ______________

Emergency Contact/Parent Contact ______________________________ phone # ______________

How did you hear about us? ______________________________

If you were referred by Family/Friend or other, whom shall we thank for your referral? ______________________________

PRIMARY INSURANCE POLICY

Insurance Company ______________________________ Policy # ______________

Sub ID # ______________________________

Policy Holders Name ______________________________

Policy holders Date of Birth ______________________________

Place of Employment ______________________________ Work Phone ______________

SECONDARY INSURANCE POLICY

Insurance Company ______________________________ Policy # ______________

Sub ID # ______________________________

Policy Holders Name ______________________________

Policy holders Date of Birth ______________________________

Place of Employment ______________________________ Work Phone ______________

CREDIT CARD AUTHORIZATION

Our office will gladly direct bill your insurance company on your behalf. In order to direct bill your insurance company, we kindly ask that you leave an imprint of your credit card and any amounts not covered by your insurance company will be charged to your credit card and an email receipt sent. Please advise us of any future changes in your credit card.

I authorize Aviation Dental to process invoice charges to my:

☐ Visa ☐ Mastercard ☐ Amex with Debit (Visa/Debit or other Debit Credit cards are not accepted)

Credit Card #: ______________________________

Expiry Date: ______________________________

Patient(s) on Account: ______________________________

Cardholder Name: ______________________________

E-mail Address: ______________________________

Signature: ______________________________

Date: ______________________________

The balance remaining after we have received your insurance benefits, will be charged to your credit card. This authorization will be in effect until notice of cancellation is forwarded in writing to Aviation Dental.

Aviation DENTAL

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

Patient Medical History

Physician ______________________________ Physician's Office Phone____________

Question	YES	NO
1. Are you currently under any medical treatment?_________________________________	☐	☐
2. Have you been admitted to a hospital or needed emergency care during the past two years?_____	☐	☐
3. Are you currently taking any medications, including over the counter medications?___________	☐	☐
Please list:____		
4. Have you ever had any complications following dental treatment?_______________________	☐	☐

5. Do you have or have had any of the following? Please check all that apply.

☐ AIDS/HIV	☐ Fainting	☐ Respiratory Problems
☐ Anemia	☐ Glaucoma	☐ Rheumatic Fever
☐ Arthritis	☐ Head Injuries	☐ Rheumatism
☐ Artificial Joints	☐ Heart Disease/Angina	☐ Sinus Problems
☐ Asthma	☐ Heart Murmur	☐ Stomach Problems
☐ Blood Disease	☐ Hepatitis	☐ Stroke
☐ Cancer	☐ High Blood Pressure	☐ Tuberculosis
☐ Diabetes	☐ Kidney Disease	☐ Thyroid Disease
☐ Dizziness	☐ Liver Disease	☐ Tumors
☐ Drug/Alcohol Dependency	☐ Mental Disorders	☐ Venereal Disease
☐ Epilepsy	☐ Pacemaker	☐ Smoker
☐ Excessive Bleeding	☐ Radiation Therapy	☐ Osteoporosis Medications (e.g. Fosamax, Actone)

Question	YES	NO
6. Are there any conditions or diseases not listed above that you have or ever had? If yes, please explain:____	☐	☐
7. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer, or heart disease) If yes, please explain: _____________________________________	☐	☐
8. Do you have a history of snoring/sleepapnea?_________________________________	☐	☐
If so, do you use a mouth breather?______________________________________	☐	☐
Do you often find it difficult to breathe through your nose?_______________________	☐	☐

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

9. Do you have any allergies to medications? ______ ☐ ☐
10. Please list your allergies to any medications: ______

______

WOMEN ONLY

13. Are you pregnant? ______ ☐ ☐
14. What is your due date? ______
15. Are you breast feeding? ______ ☐ ☐

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) ______ ☐ ☐
2. Have you had an unfavorable dental experience? ______ ☐ ☐
3. Have you ever had trouble getting numb or had any reactions to local anesthetic? ______ ☐ ☐
4. Did you ever have braces, orthodontic treatment or had your bite adjusted? ______ ☐ ☐
5. Have you had any teeth removed or missing teeth that never developed? ______ ☐ ☐

GUM AND BONE

6. Do your gums bleed or are they painful when brushing or flossing? ______ ☐ ☐
7. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _ ☐ ☐
8. Have you ever noticed an unpleasant taste or odor in your mouth? ______ ☐ ☐
9. Is there anyone with a history of periodontal disease in your family? If so indicate who: ______

______ ☐ ☐

10. Have you ever experienced gum recession? ______ ☐ ☐
11. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ______ ☐ ☐
12. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ____ ☐ ☐

TOOTH STRUCTURE

13. Have you had any cavities within the past 3 years? ______ ☐ ☐
14. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ______ ☐ ☐
15. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ______ ☐ ☐
16. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ____ ☐ ☐
17. Do you have grooves or notches on your teeth near the gum line? ______ ☐ ☐
18. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ______ ☐ ☐
19. Do you frequently get food caught between any teeth? ______ ☐ ☐

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PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

BITE AND JAW JOINT

Question	YES	NO
20. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
21. Do you feel like your lower jaw is being pushed back when you bite your teeth together?_________	☐	☐
22. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ____________	☐	☐
23. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ____________	☐	☐
24. Are your teeth becoming more crooked, crowded, or overlapped? ____________	☐	☐
25. Are your teeth developing spaces or becoming more loose? ____________	☐	☐
26. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?_____	☐	☐
27. Do you place your tongue between your teeth or close your teeth against your tongue?_________	☐	☐
28. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ___	☐	☐
29. Do you clench your teeth in the daytime or make them sore? ____________	☐	☐
30. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?____________	☐	☐
31. Do you wear or have you ever worn a bite appliance?____________	☐	☐

SMILE CHARACTERISTICS

Question	YES	NO
32. Have you been disappointed with the appearance of previous dental work?____________	☐	☐
33. Have you felt uncomfortable or self conscious about the appearance of your teeth?_________	☐	☐
34. Is there anything about the appearance of your teeth that you would like to change? _________	☐	☐
35. Have you ever whitened (bleached) your teeth?____________	☐	☐

CONSENT FOR SERVICES

I agree to pay value of said services which shall be as billed, unless objected to by me, in writing, within the time for payment thereof. I agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I understand my personal information disclosed is protected by the Privacy Act. I agree that Aviation Dental can electronically file dental claims on my behalf.

I have read the above conditions of treatment and payment and agree to their content.

Signature______________________________________ Date____________________

Patient, parent, or guardian