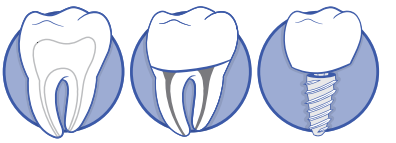
Referred by: _____



MESA FAMILY DENTISTRY

PERSONAL INFORMATION:

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt#_____

City _____ ZIP: _____

Date of Birth: _____ SS#: _____ Physician and Office #: _____

Phone #: Home _____ Mobile _____ Work _____

Employer: _____

EMAIL:_____

RESPONSIBLE PARTY AND DENTAL INSURANCE INFORMATION:

Name: _____ DOB:_____ Home phone# _____

Dental Insurance: _____Name of Insured _____

Employer of Insured: _____ Group# _____ SS# or ID# of Insured_____

MEDICAL AND HEALTH HISTORY: Have you ever had any of the following?

PLEASE CHECK YES OR NO

	YES	NO
Abnormal bleeding	☐	☐
Anemia	☐	☐
Asthma	☐	☐
Diabetes (I, II, Pregnancy) Please circle one	☐	☐
Dialysis	☐	☐
Gastric Problems	☐	☐
Heart Attack _____ Date	☐	☐
Valley Fever	☐	☐
Heart Murmur	☐	☐
Hepatitis (A, B, C, D, E) Please circle one	☐	☐
High Blood Pressure	☐	☐
HIV or AIDS Please circle one	☐	☐
Intestinal problems	☐	☐
Joint Replacement _____	☐	☐
Kidney problems	☐	☐
	☐	☐
Liver problems	☐	☐
Psychiatric treatment	☐	☐
Rheumatic Fever	☐	☐
Sexually Transmitted Disease	☐	☐
Stroke _____ Date	☐	☐
Tuberculosis	☐	☐
Urinary tract problems	☐	☐
	☐	☐

Any other medical conditions not listed above:

_____

List any surgeries: (Please include date)

_____

_____

Are you allergic to any medication? YES ☐ NO ☐ LATEX allergies? YES ☐ NO ☐

Which ones?_____

What Rx medications are you taking? _____

What "over-the-counter" medications? _____

What vitamin or herbal supplements? _____

Do you use any type of recreational drugs? YES ☐ NO ☐
(This can affect patients receiving anesthesia. All information is confidential.)

Women Only: Are you taking oral birth control? YES ☐ NO ☐ Are you pregnant? YES ☐ NO ☐

If so, what trimester? _____

What is the name and office telephone number of your OBGYN? _____

Do you smoke? YES ☐ NO ☐ How many packs per day? _____ Have you ever tried to quit? YES ☐ NO ☐

Vapor E-Cig YES ☐ NO ☐ Do you use smokeless tobacco? YES ☐ NO ☐

How much, how often, which side of mouth? _____

AUTHORIZATION OF RELEASE:

I realize my dentist must occasionally confer with medical and dental specialists concerning my physical health as well as my dental health. Furthermore, I hereby subscribe that the above information is truthful and I consent to the release of medical and dental information related to my dental treatment.

Signed: _____ On this date: _____

MESA FAMILY DENTISTRY

DENTAL HISTORY:

When was your last full set of dental x-rays, including 4 bite-wings and 14 periapical x-rays? _____

	YES	NO
Do you have any unhealed injuries, sores, ulcers, or inflamed areas in or around your mouth?	☐	☐
Do you have any growths or swellings in or around your mouth?	☐	☐
Does your mouth hurt when you chew or clench?	☐	☐
Does your jaw hurt or do you have temporal headaches when you wake?	☐	☐
Do you have pain around your ears when you chew or when you wake?	☐	☐
Have you ever had dental anesthetic (ie Novocaine)?	☐	☐
Have you ever had an adverse reaction associated with dental anesthetic?	☐	☐

Explain:_____

Have you ever had any difficulties with dental treatment in the past?	☐	☐

Explain:_____

_____

Do you wish to know more about dental cosmetic procedures?	☐	☐
Do you wish to know more about dental whitening procedures?	☐	☐
Have you ever considered orthodontic or smile design treatment?	☐	☐

OFFICE POLICY: Please initial each section.

_____I understand that a detailed financial policy is available to me upon request and that I am fully responsible for all the information in it whether I obtain and read a copy or not. The financial policy outlines specific fees for missed appointment fees, service fees, late fees, etc. (There is a $25 fee per ½ hour for a "no-show" appointment)

_____The dentist and dental hygienists see only one patient at a time, not only for your convenience, but for all patients' convenience. Unless cancelled at least one business day in advance, our policy is to charge for missed appointments. Also, your appointment lengths are based on the work being done that day. If you are late, you may not get all scheduled treatments done, or possibly none at all on the given date.

_____ Regardless of marital status, I understand that which ever parent brings a child to the office, I am responsible. This office does not get involved in court proceedings regarding medical/dental payment of services.

_____I understand that a copy of Mesa Family Dentistry's Notice of Privacy Practices is available to me upon request.

_____Minors must be accompanied by parent/guardian for all appointments. Minors that are accompanied by an older sibling (or not accompanied at all) will be rescheduled at a time when a parent or guardian can be in attendance.

_____We submit to insurance as a courtesy. You are ultimately responsible for any and all fees incurred. If you have a secondary insurance, please provide all information to us, the primary insurance does not have this information.

_____According to Arizona state law, the original x-rays taken in this dental office are property of the dental office and must stay in your chart at this location. However, copies are available upon request. There are fees to copy x-rays. You and only you can pick up and sign for your copies. You must allow up to one week for copies to be made available to you.

I HAVE READ, RECOGNIZE, AND UNDERSTAND THE OFFICE POLICIES:

Patient Signature_____ Date_____