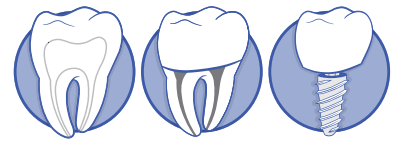


Referred by: \_\_\_\_\_



# 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

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

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: \_\_\_\_\_



**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? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any growths or swellings in or around your mouth? .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your mouth hurt when you chew or clench? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your jaw hurt or do you have temporal headaches when you wake? .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have pain around your ears when you chew or when you wake? .....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had dental anesthetic (ie Novocaine)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had an adverse reaction associated with dental anesthetic? .....                     | <input type="checkbox"/> | <input type="checkbox"/> |

Explain: \_\_\_\_\_

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

Explain: \_\_\_\_\_

- |   |                          |                          |
|---|--------------------------|--------------------------|
| Do you wish to know more about dental cosmetic procedures? .....      | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wish to know more about dental whitening procedures? .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever considered orthodontic or smile design treatment? ..... | <input type="checkbox"/> | <input type="checkbox"/> |

**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 \_\_\_\_\_