Dental Care of MESA

Health & Dental History

Patient's Name_____ Date of Birth_____ Phone_____
Mailing Address_____Zip_____email_____
Physical Address_____City_____State_____Zip_____
SS#_____single/married/widow/other Employer_____
How did you hear about our office? _____

Family Physician_____ Town_____Phone #_____
Have you been under the care of a medical doctor in the past two years? Yes or No
Are you taking any medications now? _____
Including aspirin? Yes or No Dosage? _____
Are you aware of having an allergic reaction to any medications or substances? Yes or No

Are you pregnant? _____Nursing? _____Taking Birth Control Pills? _____
Have you seen an ENT (ear, nose and throat doctor)? Yes or No Name_____
Have you seen a chiropractor? Yes or No Name_____
Have you seen a neurologist? Yes or No Name_____

Have you ever had braces? Yes or No have you ever had cosmetic dental procedures? _____
Would you like your smile to look better or different? Yes or No
Does Floss shred when you use it? Yes or No Does your breath concern you? Yes or No
Does food pack between your teeth? Yes or No Do you smoke or chew tobacco? Yes or No
Do your gums bleed? Yes or No

Indicate which of the following you have had, or have at present; Circle "Yes" or "No" to each of them:

Heart disease	Yes or No	Chronic Headaches	Yes or No
Heart Murmur	Yes or No	Jaw Pain or Jaw Popping	Yes or No
High Blood Pressure	Yes or No	Limited Opening	Yes or No
Mitral Valve Prolapse	Yes or No	Congested Ears	Yes or No
Artificial Heart Valve	Yes or No	Dizziness	Yes or No
Pacemaker	Yes or No	Ringing of the Ears	Yes or No
Stroke	Yes or No	Loose teeth	Yes or No
Asthma	Yes or No	Posture Problems	Yes or No
Liver Disease/Jaundice	Yes or No	Clenching	Yes or No
Latex Sensitivity	Yes or No	Grinding	Yes or No
Artificial Joints	Yes or No	Facial Pain	Yes or No
Neurological Disorders	Yes or No	Sensitive Teeth	Yes or No
Radiation/Chemotherapy	Yes or No	Neck Ache	Yes or No
Epilepsy/Seizures	Yes or No	Bell's palsy	Yes or No
Diabetes	Yes or No	Difficulty Chewing	Yes or No
Hepatitis	Yes or No	Tingling in arms/fingers	Yes or No
AIDS/HIV	Yes or No	Insomnia/frequent waking	Yes or No
Sickle Cell Disease	Yes or No	any disease/condition not listed? _____	

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any changes in my health or medication.

Signature_____ **Date**_____

HEALTH INFORMATION: I agree to disclose all previous illnesses, medical and dental history (e.g. gum disease) including all medications. Undisclosed medical information and current medication, allergies or illnesses are risk factors. I agree to allow the use of my information only where it is necessary for treatment or to process insurance claims.

DRUGS, LATEX AND MEDICATION: I understand that antibiotics and other medications can cause allergic reactions and/or anaphylaxis, which is a potentially life-threatening condition that can interfere with normal breathing. Also, some antibiotics interfere with birth-control pills. Latex allergy can cause rashes and itching. Epinephrine, which is used in some dental injections, increases heartbeat and depending on my health status, may be dangerous.

NEEDLE STICK: If a staff member is inadvertently stuck with a needle used on me, I consent to a blood test for analysis.

FILLINGS, CROWNS AND UNATICIPATED ROOT CANALS: It is possible that a tooth will need a root canal, even after a simple filling or crown is done.

PORCELAIN CROWNS, VENEERS, BONDING AND COSMETIC FILLINGS: Once a crown, veneer, bonding or filling is placed, I understand the color cannot be changed without a remake and that they can chip or break just like real teeth. I will ask to be counseled, informed and educated on how it is important to maintain a healthy balanced occlusion (bite) if I have any questions. I know that this may be complicated do to stress, clenching, muscles, teeth and genetics. I am aware that most people grind their teeth subconsciously, which is damaging to the teeth and can break teeth or dental restorations. I have been informed about the need to wear an occlusal splint for protection.

GUM TREATMENT VS. "JUST A CLEANING": If I do not floss or if I smoke, I can expect to have a deteriorating gum condition called periodontal (gum) disease. Certain medical conditions and medications can be relative to periodontal disease. I am aware that periodontal disease requires more treatment than a simple cleaning.

EXTRACTIONS AND SURGERY: I understand that all tooth extractions or dental surgeries carry risks. Some are minor, like a dry socket following an extraction. Some could be life threatening, such as post-surgical infection or anaphylaxis.

FEE FOR ADDITIONAL CARE OR SPECIALTY CARE: I understand that I may need treatment beyond what is originally planned (e.g. crowned tooth may still need a root canal and may be referred to a specialist for additional care).

LIMITATION OF INSURANCE COVERAGE: Often there are charges beyond what insurance will pay (e.g. sterilization fees, nitrous oxide, temporary dentures, bleaching or cosmetic work).

24-HOUR NOTICE OF CANCELLATION: I agree to give 24-business hours notice of cancellations or I will pay the broken appointment fee. I understand that leaving a message after the office is closed for the day (or weekend) before my appointment is NOT sufficient notice.

REQUESTING RECORD TRANSFER: Professional courtesies occur between dental offices. I understand that any previous records will be sent directly to this dental office only.

DENTAL APPOINTMENTS: If I am more than 15 minutes late for any appointment without calling the office, I will either accept what appointment time is left, or will reschedule and pay the broken appointment fee.

APPOINTMENT TIMES AND EMERGENCY CARE: It is our office policy and philosophy to be ready for any guest in discomfort or in an emergency situation. This courtesy is extended to all patients and we ask for your understanding when these unexpected situations arise. Out of respect for your time, we will keep you informed of such times. We thank you in advance for your patience.

Signed _____DATE_____

Dental Care of Mesa Payment and Consent for Services

- Please note that our office will do our best to maximize your insurance benefits. Amounts not covered or denied by your insurance will be your responsibility and either due at the time of service or upon receipt of a billing statement.
- Our office will proudly present an estimate for treatment and an estimated portion that your insurance will not cover. Please let us know if you are not aware of the amount that will be due at time of service and we will be happy to supply you with this information.
- Our office will send you a billing statement with the amount due if there should be an outstanding balance after insurance has paid for services. We will contact you should your insurance company pay more than estimated and will apply your credit as requested.
- A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days. If after 90 days, your account will be turned over to a collections agency or credit bureau. You would then be responsible for any legal fees.
- We appreciate that our patients' time is extremely valuable, as is ours. Please respect others by arriving to appointments as scheduled.
- Please provide our office **two business days notification should you need to cancel** so that we are able to make this time available for other patients. If sufficient notification is not provided you may be subject to a broken appointment fee. A minimum **$40.00 cancellation fee may apply**. **INITIAL_____**

I have read, understand, and give my consent to the above conditions of payment and consent for services.

Patient Name Printed: _____ Date: _____

Patient Signature: _____