

# mesa dental

FAMILY AND COSMETIC DENTISTRY

Everything you need for a healthy smile

## WELCOME PAGE - Q & A

### We Warmly Welcome You

To better serve you, please take just a couple minutes to answer the following questions. Thanks!

Please check any of the following problems that apply to you:

- Sensitivity (hot, cold or sweet)
- Headaches, earaches, neck pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen, or irritated gums
- Loose, tipped or shifting teeth
- Bad breath

Do you have or have you had any of the following?

- Dentures
- Partial Dentures
- Peridental (gum) treatments

Please share the following approximate dates:

Your last cleaning \_\_\_\_\_

Your last oral cancer screening \_\_\_\_\_

Your last complete x-rays \_\_\_\_\_

Who was your previous dentist?

Name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Phone: \_\_\_\_\_

What are the most important things to you about your smile and dental health? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you smoke or use chewing tobacco? Yes No

If yes, how much? \_\_\_\_\_

And, for how long? \_\_\_\_\_

If you could change your smile, would you?

(Please check all that apply)

- Make your teeth whiter
- Make your teeth straighter
- Close spaces between teeth
- Replace black metal fillings with tooth-colored restorations
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

On a scale of 1 to 5, with 5 being the highest rating:

(Please circle the numbers that best applies)

How important is your dental health to you?

1  2  3  4  5

How would you rate your current dental health?

1  2  3  4  5

Why did you leave your previous dentist?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is the most important thing to you about your dental visit today?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## PATIENT ACKNOWLEDGEMENTS

PLEASE FILL OUT THIS FORM COMPLETELY

### 1 About You

Name \_\_\_\_\_

Preferred Name \_\_\_\_\_  Male  Female

Single  Married  Divorced  Widowed  Separated

Birthdate / / Age \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_

Mobile # \_\_\_\_\_ Fax # \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Other family seen by us? \_\_\_\_\_

Last visit date \_\_\_\_\_

Employer \_\_\_\_\_

Employer # \_\_\_\_\_ How long there? \_\_\_\_\_

### 2 Account Info

Personal Responsible for Account

Name \_\_\_\_\_ Relation \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_

Mobile # \_\_\_\_\_ Fax # \_\_\_\_\_

Email \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### 3 Spouse Information

Name \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_

Mobile # \_\_\_\_\_ Birthdate / /

Email \_\_\_\_\_

### 4 Insurance

Provider Insurance \_\_\_\_\_

Provider Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relation \_\_\_\_\_

Insured's Birthdate \_\_\_\_\_ Insured's ID # \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's Ph # \_\_\_\_\_

#### SECONDARY INSURANCE

Provider Insurance \_\_\_\_\_

Provider Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relation \_\_\_\_\_

Insured's Birthdate \_\_\_\_\_ Insured's ID # \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's Ph # \_\_\_\_\_

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## PATIENT INFORMATION FORM - SECTION 2

PLEASE FILL OUT THIS FORM COMPLETELY

### 5 Medical History

Your current physical condition  Good  Fair  Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs?  Yes  No

Please list each one \_\_\_\_\_

Have you ever taken Bisphosphonates?  Yes  No

(Known as Fosamax, Actonel, etc.) if yes, when? \_\_\_\_\_

#### FOR WOMEN ONLY

Are you taking birth control pills?  Yes  No

Are you pregnant?  Yes  No

Are you nursing?  Yes  No

#### HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

- Y  Abnormal Bleeding
- Y  Alcohol/Drug Abuse
- Y  Anemia
- Y  Arthritis
- Y  Artificial Bones, Joints or Valves
- Y  Asthma
- Y  Blood Transfusion
- Y  Cancer/Chemotherapy
- Y  Colitis
- Y  Congenital Heart Defect
- Y  Diabetes
- Y  Difficulty Breathing
- Y  Emphysema
- Y  Epilepsy
- Y  Fainting Spells
- Y  Frequent Headaches
- Y  Glaucoma
- Y  Heart Attack
- Y  Heart Surgery
- Y  Hemophilia

- Y  Hepatitis
- Y  Herpes/Fever Blisters
- Y  High Blood Pressure
- Y  HIV+/AIDS
- Y  Kidney Problems
- Y  Liver Disease
- Y  Lupus
- Y  Osteoporosis
- Y  Pacemaker
- Y  Psychiatric Care
- Y  Radiation Treatment
- Y  Seizures
- Y  Sickle Cell Disease
- Y  Sinus Problems
- Y  Stroke
- Y  Thyroid Problems
- Y  Tuberculosis (TB)
- Y  Ulcers
- Y  Venereal Disease

Please list any medical condition not mentioned above: \_\_\_\_\_

Have you ever been hospitalized for any reason? List why: \_\_\_\_\_

#### ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

- Y  Aspirin
- Y  Codeine
- Y  Dental Anesthetics
- Y  Erythromycin
- Y  Jewelry/Metals
- Y  Latex
- Y  Penicillin
- Y  Terracycline

Please list any allergies not mentioned above: \_\_\_\_\_

### 6 Medical Information

Are you currently under the care of a physician?  Yes  No

Please explain: \_\_\_\_\_

Physician's Name \_\_\_\_\_

Phone # \_\_\_\_\_ Last Visit \_\_\_\_\_

#### IN THE CASE OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name \_\_\_\_\_ Relation \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_

### 7 Dental History

Why have you come to the dentist today? \_\_\_\_\_

Has your doctor told you that you require antibiotics before dental treatment? Yes  No

Are you currently in pain? Yes  No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes  No

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes  No

Your Current dental health is? Good  Fair  Poor

Do you like your smile? Yes  No

Do your gums ever bleed? Yes  No

How many times a week do you use floss?

How many times a day do you brush?

Type of toothbrush bristles?  Hard  Medium  Soft

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## 8 Disclaimer

*I understand that the information I have given today is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical and insurance status. I also understand that this information will be held in the strictest of confidence. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.*

*Since payment is due in full at the time of treatment (unless other arrangements have been approved), I am responsible for any amount not covered by my insurance. For all patient balances that become older than 90 days, I agree to pay all costs associated with collections and attorney fees if suit be instituted hereunder. I will do everything withing my power to give at least 24 hour notice. I realize that failure to do so may result in a \$25 fee.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please feel free to discuss any questions or concerns you may have regarding our policies. We feel honored that you have chosen us.

## 9 Privacy Practices

**Ehsan Nasery D.D.S.**

### **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

**\*\*You may refuse to sign this acknowledgement\*\***

I, \_\_\_\_\_, understand that Dr. Nasery's Office abides by the HIPAA Law and will protect the privacy of my personal information. A copy of our Notice of Privacy Practices available if requested.

Please Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

### **FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgment for the receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited us from obtaining acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (Please Specify)