Welcome to Mission Family Dentistry

We are pleased to welcome you to our practice.
Please take a few minutes to fill out this form as completely as possible.
If you have questions we will be glad to help you.
We look forward to working with you to maintain your dental health.

Patient Information

Name _____ Nickname _____

Address _____ City _____ Zip _____

Preferred Method of Contact: ❑ Mail ❑ Email ❑ Home Phone ❑ Cell Phone

Phone (home) _____ (work) _____ (cell) _____ E-mail _____

Birthdate _____ Age _____ Social Security # _____

Patient Employed by _____ Occupation _____

Whom may we thank for referring you? _____ ❑ Married ❑ Single Spouse Name _____

Notify in case of emergency _____ Phone _____

Dental Insurance

Insured Party _____ Relation to Patient _____

Social Security # _____ Birthdate _____ ID # _____

Address (if different from patient) _____ Phone _____

Insured Party Employed by _____

Insurance Company _____ Group # _____ Phone _____

Additional Dental Insurance _____

Authorization & Consent

I have received the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate dental treatment. During treatment, I will report any change in my medical status to the dentist, including hospitalizations or medications that I am taking in addition to those reported in my medical history.

I give my consent to you and your staff to administer anesthetics, and to employ any operative and technical procedures including any diagnostic aids necessary for diagnosis and treatment of my oral condition. I understand that during treatment it may be necessary to change or add procedures due to conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any changes and additions as necessary.

In consideration of professional serviced rendered to me, I agree to pay for services at the time they are rendered. If applicable, I authorize the insurance company indicated on this form to pay the dentist all benefits otherwise payable to me for services. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges, whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been made.

Dental History

Reason for visit: ❑ complete exam ❑ pain ❑ broken tooth ❑ other _____

Would you like information on: ❑ bleaching ❑ implants ❑ cosmetic dentistry ❑ other _____

Previous Dentist _____ Phone _____

Address _____

Date of last dental visit _____ Date of last x-rays _____

Have you experienced any of the following:

❑ bleeding, painful gums ❑ grinding or clenching teeth ❑ sores or growths in mouth

❑ bad breath ❑ pain in joint, ear, side of face ❑ gum treatments

❑ loose teeth ❑ difficulty chewing ❑ braces

❑ periodontal treatment

Are your teeth sensitive to: ❑ hot ❑ cold ❑ sweet ❑ biting?

How do you feel about the appearance of your teeth? _____

Does dental treatment make you nervous? ❑ no ❑ slightly ❑ moderately ❑ severely

Have you had a bad experience in any dental office? Please explain: _____

_____

Medical History

Physician's Name _____ Phone _____

Date of last visit? _____ Serious illness or operations? _____ When? _____

(Women) Are you pregnant? _____ Breast feeding? _____ Taking birth control? _____

Do you smoke? _____ Have you smoked in the past? _____ How long ago? _____

Have you ever had the following?

Yes	No		Yes	No		Yes	No	
❑	❑	AIDS/HIV Positive	❑	❑	Cholesterol Problems	❑	❑	Kidney disease
❑	❑	Artificial joints (hip, knees)	❑	❑	Cough (persistent)	❑	❑	Liver disease
❑	❑	Anemia	❑	❑	Cortisone treatments	❑	❑	Mitral valve prolapse
❑	❑	Artificial heart valves	❑	❑	Diabetes	❑	❑	Pacemaker
❑	❑	Arthritis	❑	❑	Epilepsy	❑	❑	Psychatric care
❑	❑	Asthma	❑	❑	Glaucoma	❑	❑	Rheumatic/Scarlet fever
❑	❑	Back problems	❑	❑	Heart attack	❑	❑	Shingles
❑	❑	Blood disease	❑	❑	Heart murmur	❑	❑	Stroke
❑	❑	Blood pressure (hi or low)	❑	❑	Hemophelia	❑	❑	Steroid treatments
❑	❑	Cancer/Tumor	❑	❑	Headaches	❑	❑	Thyroid disease
❑	❑	Chemical dependency	❑	❑	Herpes	❑	❑	Tuberculosis
❑	❑	Chemotherapy/Radiation	❑	❑	Hepatitis	❑	❑	Venereal disease

Have you ever been told by your physician that you needed to premedicate with antibiotics prior to dental treatment? _____

List all allergies (including medications / food/ latex):

_____

_____

List all medications you are currently taking

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have any disease, condition or problem not addressed above that you think we should know about? Please explain:

_____

_____

_____

_____

For Office Use Only

Reviewed by: _____

Date: _____

_____

_____