

# Mona Lisa Dental

## Patient Information

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Last, First MI (Preferred Name)  
**Gender (circle):** Male / Female **Marriage Status** \_\_\_\_\_  
**Social Security #:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
**Phone (Home):** \_\_\_\_\_ **(Work):** \_\_\_\_\_ **(Cell):** \_\_\_\_\_  Home  Work  Cell  
Check Preferred Number to call  
**Email Address:** \_\_\_\_\_  
**Home Address:** \_\_\_\_\_  
Street City State Zip Code  
**Employer Name:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_  
**Employer Address:** \_\_\_\_\_  
Street City State Zip Code

## Dental Information

Do you have a specific dental problem? Describe: \_\_\_\_\_  
Do you have dental examinations on a routine basis? \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
Do you brush and floss on a routine basis? \_\_\_\_\_  
Do you think you have active decay or gum disease? \_\_\_\_\_  
Do your gums ever bleed? \_\_\_\_\_  
Do you like your smile? Why? \_\_\_\_\_  
Does food catch between your teeth? Do you have any loose teeth? \_\_\_\_\_  
Do you want to keep your remaining teeth? \_\_\_\_\_  
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? \_\_\_\_\_  
Have your past experiences in the dental office always been positive? \_\_\_\_\_  
Do you smoke or chew? Are there any sores or growths in your mouth? Do you consume alcohol? \_\_\_\_\_  
Name of previous dentist? (Optional) \_\_\_\_\_  
Date of your last full mouth x-rays? \_\_\_\_\_

## Health Information

**Have you ever had any of the following? Please check those that apply:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Heart Trouble /Disease    | <input type="checkbox"/> Blood Disease        | <input type="checkbox"/> Emphysema                  | <input type="checkbox"/> Hepatitis A or B            |
| <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Bruise easily        | <input type="checkbox"/> Tuberculosis               | <input type="checkbox"/> Kidney problems             |
| <input type="checkbox"/> Irregular Heart Beat      | <input type="checkbox"/> Anemia               | <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Renal Dialysis              |
| <input type="checkbox"/> Angina / Chest Pain       | <input type="checkbox"/> Excessive Bleeding   | <input type="checkbox"/> X-ray Treatment(radiation) | <input type="checkbox"/> Thyroid/Parathyroid Disease |
| <input type="checkbox"/> Heart Attack / Failure    | <input type="checkbox"/> Sickle Cell Disease  | <input type="checkbox"/> Chemotherapy               | <input type="checkbox"/> Arthritis / Gout            |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hemophilia(Bleeding) | <input type="checkbox"/> Stomach/Intestinal Disease | <input type="checkbox"/> Rheumatism                  |
| <input type="checkbox"/> Mitral Valve Prolapse     | <input type="checkbox"/> Leukemia             | <input type="checkbox"/> Ulcers                     | <input type="checkbox"/> Pain in jaw joint           |
| <input type="checkbox"/> Rheumatic Fever           | <input type="checkbox"/> Blood Transfusion    | <input type="checkbox"/> Recent weight loss         | <input type="checkbox"/> Cortisone medications       |
| <input type="checkbox"/> Artificial Heart Valve    | <input type="checkbox"/> Swelling of limbs    | <input type="checkbox"/> Frequent Diarrhea          | <input type="checkbox"/> Artificial Joint            |
| <input type="checkbox"/> Heart Pace Maker          | <input type="checkbox"/> Lung Disease         | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Venereal disease            |
| <input type="checkbox"/> Heart Surgery             | <input type="checkbox"/> Frequent cough       | <input type="checkbox"/> Excessive thirst           | <input type="checkbox"/> AIDS / HIV +                |
| <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Asthma / Hay Fever   | <input type="checkbox"/> Hypoglycemia               | <input type="checkbox"/> Drug Addiction              |
| <input type="checkbox"/> Low Blood Pressure        | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Liver Disease              | <input type="checkbox"/> Cold sores/fever blisters   |

- Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Have you been ever been hospitalized or had a major operation?  Yes  No Injury to head or neck?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- **Are you taking any medications, pills or drugs? List?** \_\_\_\_\_
- **Are you allergic to any medications or substances? Please check below:**  
 Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex rubber  Other \_\_\_\_\_
- **FOR WOMEN: Are you pregnant or trying to get pregnant?**  Yes  No
- Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian \_\_\_\_\_ **Date:** \_\_\_\_\_

### Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment

**Name:** \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_

**Social Security #:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

**Phone (Home):** \_\_\_\_\_ **(Work):** \_\_\_\_\_ **Ext:** \_\_\_\_\_ **Best time to call:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
Street \_\_\_\_\_ Apartment # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Employer Name:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_  
Street \_\_\_\_\_ City, \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

### Insurance Information

**Primary**

**Name of Insured:** \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

**Insured's Birth Date:** \_\_\_\_\_ **ID #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Insured's Address:** \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Insured's Employer Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

**Insurance Plan Name and Address:** \_\_\_\_\_

**Secondary**

**Name of Insured:** \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

**Insured's Birth Date:** \_\_\_\_\_ **ID #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Insured's Address:** \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Insured's Employer Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

**Insurance Plan Name and Address:** \_\_\_\_\_

### Referral Information

Whom may we thank for referring you to our practice?  Website  Insurance website  Yellow Pages  Qwest Dex  
 Gilbert Lifestyle Magazine  Catholic Sun  Newspaper  School  Work  Postcard in the mail  Other: \_\_\_\_\_  
 Another patient: Name of person or office referring you to our practice: \_\_\_\_\_

### Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
**Signature of patient, parent or guardian** **Date:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of guarantor of payment/responsible party** **Date:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_