Matheson Dentistry

20713 East Ocotillo Road | Suite 102 | Queen Creek, Arizona 85142
480.888.8123 ph | 480.888.8374 fax
dralex@mathesondentistry.com email | www.mathesonsondentistry.com web

Patient Information

Name:

LAST FIRST MIDDLE PREFERED NAME

Birthdate: Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single

Social Security #: Driver's License #: State:

Address:

Please provide all telephone numbers to contact you. There may be times when we need to reach you on short notice.

Home: Work: *ext* Cell:

E-mail address *(optional)*: Other:

Is one of your immediate family members a patient here? Y / N Name:

How did you hear about us?

Primary Insurance

Insured's Name:

LAST FIRST MIDDLE

Social Security #: Birthdate: Insured's Employer:

Insurance Co.: Group #: Insurance Phone #:

Insurance Address:

Secondary Insurance *(if applicable)*:

Insured's Name:

LAST FIRST MIDDLE

Social Security #: Birthdate: Insured's Employer:

Insurance Co.: Group #: Insurance Phone #:

Insurance Address:

Responsible Party Information:

Self: Y / N Other:

LAST FIRST MIDDLE

If "Other" please complete the following:

Relationship to Patient:

Birthdate: SS #: Driver's License #:

Address:

Home Phone: Work Phone:

Emergency Contact Information:

Name: Relationship to Patient:

Address: Phone:

Dental History

Do you require antibiotics before dental treatment? ☐ Y ☐ N

Are you currently in pain? ☐ Y ☐ N

Have you ever had a serious or difficult problem associated with any previous dental work? ☐ Y ☐ N

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do your gums bleed easily *(e.g. when flossing)?* ☐ Y ☐ N

How many times a week do you floss?

How many times a day do you brush?

Are your teeth sensitive to heat, cold, or anything else? ☐ Y ☐ N

Have you ever had gum/periodontal treatment? ☐ Y ☐ N

Do you now or have you ever experienced pain discomfort in your jaw joint *(TMJ/TMD)*? ☐ Y ☐ N

Do you grind your teeth? ☐ Y ☐ N

Do you ever experience slow healing sores in your mouth? ☐ Y ☐ N

Do you participate in sports? ☐ Y ☐ N

Do you use a protective mouthguard? ☐ Y ☐ N

Have you ever experienced dental, oral or facial trauma? *(e.g. a blow to the jaw)* ☐ Y ☐ N

Are you interested in whitening your teeth? ☐ Y ☐ N

Is there anything about the appearance of your teeth you would like to change?

Medical History

Do you have a personal physician? ☐ Y ☐ N

Physician's Name:

Phone #:

Date of last visit:

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any form? ☐ Y ☐ N

Are you currently under the care of a physician? ☐ Y ☐ N

Please explain:

For Women: Are you taking a prescribed contraceptive? ☐ Y ☐ N

Are you pregnant? ☐ Y ☐ N ☐ Unsure Due Date:

Are you nursing? ☐ Y ☐ N

Have you ever had any of the following

HEART PROBLEMS

Heart attack	☐ Y	☐ N
Difficulty breathing	☐ Y	☐ N
Blood pressure problems	☐ Y	☐ N
Heart murmur	☐ Y	☐ N
Heart valve problems/ artificial valve	☐ Y	☐ N
Rheumatic/Scarlet fever	☐ Y	☐ N
Pacemaker	☐ Y	☐ N
Heart surgery	☐ Y	☐ N
Previous Endocarditis	☐ Y	☐ N

ALLERGY PROBLEMS

Hay Fever	☐ Y	☐ N
Sinus problems	☐ Y	☐ N
Asthma	☐ Y	☐ N

BLOOD PROBLEMS

Abnormal bleeding/bruising	☐ Y	☐ N
Blood disease (e.g. anemia)	☐ Y	☐ N

GASTROINTESTINAL

Ulcers/Colitis/Irritable Bowel Syndrome	☐ Y	☐ N
Kidney or bladder problems	☐ Y	☐ N
Other GI difficulties	☐ Y	☐ N

BONE OR JOINT PROBLEMS

Arthritis	☐ Y	☐ N
Back or neck pain	☐ Y	☐ N
Artificial bones or joints	☐ Y	☐ N

NEUROLOGICAL PROBLEMS

Fainting spells/ seizures/epilepsy	☐ Y	☐ N
Strokes	☐ Y	☐ N
Frequent headaches	☐ Y	☐ N

OTHER

Thyroid problems	☐ Y	☐ N
Cancer/Chemotherapy/ Radiation	☐ Y	☐ N
Diabetes	☐ Y	☐ N
Tuberculosis or other respiratory problems	☐ Y	☐ N
Alcohol/Drug Abuse	☐ Y	☐ N
Hepatitis/Jaundice/Liver problems	☐ Y	☐ N
STDs	☐ Y	☐ N
HIV+/AIDS	☐ Y	☐ N
Gluacoma/Other eye diseases	☐ Y	☐ N
Psychiatric problems	☐ Y	☐ N
Oral herpes/Fever blisters	☐ Y	☐ N
Autoimmune diseases	☐ Y	☐ N

Please list any other serious medical condition(s) that you have had:

Have you ever taken a bisphosphonate? *(Usually used to treat osteoporosis and other degenerative bone diseases -- e.g. Boniva, Fosamax, Arridia)* ☐ Y ☐ N

Please list any medications *(including over-the-counter or herbal supplements)* you are currently taking or have taken in the previous 12 months:

Are you allergic to any of the following?

Local dental anesthetics	☐ Y	☐ N
Penicillin or other antibiotics	☐ Y	☐ N
Sulfa drugs	☐ Y	☐ N
Barbituates, sedatives, sleeping pills	☐ Y	☐ N
Aspirin, Acetaminophen, Ibuprophen	☐ Y	☐ N
Codeine, Demerol, or other narcotics	☐ Y	☐ N
Reactions to metals	☐ Y	☐ N
Latex / Rubber	☐ Y	☐ N
Other:		

Notice of Privacy Practices:

I have received a copy of this office's Notice of Privacy Practices. Patient's Initials:

Financial Policy:

We bill insurance as a courtesy to our patients; however, patients are responsible for taking an active part in the recovery of their claim. Patients are financially responsible for any co-payments, deductibles, co-insurance and all charges not covered by insurance. Co-pays and deductibles will be collected at the time service is rendered. Because insurance benefits are determined when the claim is received, verification of benefits is not a guarantee of payment. Any balance remaining on the account after insurance has paid is the patient's responsibility. If the entire balance of the account is not paid within 30 days of receipt of insurance payment, a service charge of 18% will be added to the account per month. In the case of default payment, the patient is responsible for paying any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred. Patient Initials: _____

Broken Appointment Policy:

Reserved appointment time in any dental office is limited and valuable. It is extremely important that all patients honor their reserved dental appointments. Failure to do so prevents our other patients from receiving needed dental care in a timely fashion. So that the dentist, our staff and our other patients will not be penalized by those who fail to keep scheduled appointments, our office policy stipulates that failure to give sufficient warning to keep a scheduled appointment (24 hours advance notification) will result in a $75.00 fee being charged. That charge is to be paid prior to the scheduling of any new appointment. The patient is responsible for payment of the charge. Patient Initials: _____

Consent:

I have had full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my permission to Matheson Dentistry for use and disclosure of my protected health information to carry out treatment, payment, and health care operations. I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

Patient's Signature: Date:

Parent or Responsible Party: Relationship to Patient:

MEDICAL HISTORY UPDATE

OFFICE USE ONLY

I have read my medical history dated _____ and confirmed that it states past and present medical condition

Patient's Signature: Date:

I have read my medical history dated _____ and confirmed that it states past and present medical condition

Patient's Signature: Date:

I have read my medical history dated _____ and confirmed that it states past and present medical condition

Patient's Signature: Date:

I have read my medical history dated _____ and confirmed that it states past and present medical condition

Patient's Signature: Date:

I have read my medical history dated _____ and confirmed that it states past and present medical condition

Patient's Signature: Date: