

MESA IMPLANTS AND PERIODONTICS, LLC
Practice Limited to Periodontics and Implants

The following information is necessary to thoroughly evaluate your health. This information will be kept strictly confidential and will not be released to anyone. Thank you for taking the time to complete this questionnaire.

HEALTH HISTORY

Name: _____ Birth date: _____ Date: _____

Circle the answer which applies:

1. Have you been under the care of a physician or hospitalized in the past year? Yes No
Date of last examination _____
Name and address of physician _____
2. Are you taking or have you recently taken *any* prescription, OTC or herbal medication? Yes No
3. Are you allergic to or have you reacted adversely to any of the following medications? Yes No
Aspirin _____ Codeine _____ Penicillin _____ Local anesthetics _____ Latex _____ Other medications _____

4. Do you have or have you had any of the following:

Heart Disease	Yes	No	Ulcers	Yes	No
Heart surgery	Yes	No	Diabetes	Yes	No
Congenital heart lesions	Yes	No	Family history of diabetes	Yes	No
Heart arrhythmia	Yes	No	Thyroid problems	Yes	No
Pacemaker/defibrillator	Yes	No	Arthritis or rheumatism	Yes	No
High Blood Pressure	Yes	No	Joint replacement	Yes	No
Stroke / TIA	Yes	No	Osteoporosis	Yes	No
Respiratory problems	Yes	No	Tumor or growths	Yes	No
Asthma	Yes	No	Radiation or chemotherapy	Yes	No
Persistent cough	Yes	No	Alcoholism or drug addiction	Yes	No
Hay fever or allergy	Yes	No	Nervousness	Yes	No
Sinus problems	Yes	No	Glaucoma	Yes	No
Epilepsy	Yes	No			
Fainting spells or seizures	Yes	No			
Persistent headaches	Yes	No	Women Only:		
Anemia	Yes	No	Are you pregnant	Yes	No
Abnormal Bleeding	Yes	No	Do you take contraceptives	Yes	No
Bruise easily	Yes	No	Have you reached menopause	Yes	No
AIDS or HIV infection	Yes	No	Do you take hormones	Yes	No
Hepatitis or jaundice	Yes	No			

DENTAL HISTORY

Why did you seek treatment at this time? _____

Do you see a dentist regularly? Yes No Dentist's Name _____

When were your teeth last cleaned? _____

Have you ever had periodontal or gum treatment before? Yes No When _____

Are you satisfied with the way your teeth look? Yes No Is it important for you to keep your own teeth? Yes No

Do you have or have you had?

- | | | | | | |
|--|-----|----|---|-----|----|
| a) Discomfort in the teeth, gums or jaw? | Yes | No | f) Tired jaw or facial muscles? | Yes | No |
| b) Bleeding gums? | Yes | No | g) Difficulty chewing? | Yes | No |
| c) Bad taste or bad breath? | Yes | No | h) Grinding or clenching of teeth? | Yes | No |
| d) Sensitivity to temperature or pressure? | Yes | No | i) Orthodontic treatment (braces) | Yes | No |
| e) Shifting of teeth within last 5 years? | Yes | No | j) Complications with dental treatment? | Yes | No |

Which of the following do you use? Brush _____ Water Pik _____ Floss _____ Mouth Rinse _____ Toothpicks _____ Other _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change I will inform the doctor at the next appointment.

CONSENT FOR TREATMENT

I hereby authorize the doctor or his designee to utilize various diagnostic aids, medications and therapy that are deemed necessary or advisable for diagnosis and treatment. I also understand that therapeutic procedures may involve certain risks.

Signature of Patient, Parent or Guardian

Dentist Signature

Date

Mesa Implants & Periodontics, LLC

Drs. Peterson, Shlossman & Johnston

480-203-2666

PATIENT INFORMATION FORM

Date _____

Name _____

Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ City _____ Zip _____

Birth date _____ Marital Status _____ Social Security # _____

Employer _____ Occupation _____

Work address _____ City _____ Zip _____

Spouse's Employer _____ Occupation _____

Spouse's work address _____ City _____ Zip _____

Dentist _____ Years _____

Referred by _____

Who will be responsible for this account? _____

Emergency Contact and Phone #: _____

EMAIL ADDRESS: _____

PATIENTS WITH DENTAL INSURANCE

Insured Person _____ Social Security # _____

Name of Plan _____ Plan # _____

Does your spouse have dental insurance? _____ *If yes, please continue:*

Spouse's Social Security # _____ Birth date _____

Name of Plan _____ Plan # _____

FINANCIAL POLICY

It is our policy that billing procedures be clearly understood prior to the onset of treatment. Payment is expected at the time of treatment. Payment may be made by cash, personal check or credit card. Extended payments may be available through prior financial arrangements with our office manager. Any balance reflected in your statement is due within 10 days of receipt of your statement. Monthly bookkeeping fees may be applied to unpaid balances.

If you have dental insurance we will bill your primary insurance company, as a courtesy to you. Complete insurance information must be provided at the time of your first visit. All deductibles and copayments are due at the time of treatment. Please note that dental insurance is designed to help pay part of the cost of treatment. Your insurance contract is between you and your insurance company. The type of benefits in your contract depends on what your employer has negotiated and we cannot guarantee payment of your claims. We will be glad to assist you in filing for these benefits, but you are ultimately the one who is financially responsible for your treatment.

If you are unable to keep your appointment, please call us as soon as possible or leave a message if the office is closed. *A fee is assessed for missed/broken appointments without 24-hour notice.* Please understand this policy is necessary so that we may make this time available to other patients who are waiting for an appointment.

In the event that it becomes necessary to place an account in collections, the patient is responsible for any additional legal and collection related costs that may be incurred. By signing below you indicate that you have read the preceding and understand that periodontal services are rendered in accordance with these terms.

I acknowledge I have reviewed a copy of this office's Notice of Privacy Practices.

Patient Signature

Patient Signature