Mesquite Endodontics

PATIENT

Patient's Full Legal Name: Nickname: Date: **04/20/2021**

Date of Birth: Age: ☐ M ☐ F Height: Weight: Last 4 digits of SS#:

Street Address: City: State: ZIP:

Occupation: Employer:

Select one or more preferred contact methods. Select if you prefer call, text, or both for your mobile phone.

☐ Mobile Phone (☐Call ☐Text ☐Both): ☐ Work Phone: ☐ Home Phone:

☐ Personal Email Address:

Patient's DRUG AND OTHER ALLERGIES AND/OR UNPLEASANT REACTIONS: ☐ No Known Drug Allergies ☐ Allergies:	Does your doctor recommend ANTIBIOTIC PREMEDICATION before any dental procedure? If so, which antibiotic and what issue does that address: ☐ No ☐ Yes

Emergency Contact Name:	Relationship:	Phone:
General Dentist Name:	Office:	Phone:
Physician Name:	Specialty:	Phone:
Physician Name:	Specialty:	Phone:
Pharmacy:	Cross Streets:	Phone:

If you are completing this for the patient, tell us your name and relationship to the patient:

DENTAL HISTORY

Date of last dental exam/x-rays:

What makes your tooth hurt: ☐ No Pain ☐ Heat ☐ Cold ☐ Chewing ☐ Other:

Select the word(s) that best describe the pain: ☐ No Pain ☐ Sharp ☐ Dull ☐ Throbbing ☐ Spontaneous ☐ Other:

If you have had pain, how long have you had it?

If you have had pain, how do you relieve it?

Have you had trauma to that area? ☐ No ☐ Yes if so, when?

What dental work have you had on this tooth? ☐ None ☐ Filling ☐ Crown ☐ Root Canal ☐ I don't know ☐ Other:

Is there anything else that we should know about your tooth that might be helpful?

Rx & OTC DRUGS

List the medications you have taken for the tooth. Have any of these medications relieved any discomfort?

List other prescriptions and over-the-counter medications you are taking now.

MEDICAL HISTORY

Are you in good health? ☐ Yes ☐ No

Do you have active tuberculosis? ☐ Yes ☐ No

Have there been any changes in your health in the past year? If yes, please specify: ☐ Yes ☐ No

Have you had any serious illness, operation or been hospitalized in the past 5 years? If so, please explain: ☐ Yes ☐ No

Are you now under the care of a physician? ☐ Yes ☐ No

Conditions are being treated:

Have you taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine), or phen-fen (fenfluramine-phentermine combination)? ☐ Yes ☐ No

Do you have any of the following?

Recurrent infections ☐ Yes ☐ No
If yes, please specify:

Mental health disorders ☐ Yes ☐ No
If yes, please specify:

Neurological disorders ☐ Yes ☐ No
(Including Restless Leg Syndrome).
If yes, please specify:

Do you wear contact lenses? ☐ Yes ☐ No

Have you had a joint replacement? ☐ Yes ☐ No

If yes, then when?:

Any complications? ☐ Yes ☐ No

Do you have any of the following?

Mitral valve prolapse	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Rheumatic heart disease/rheumatic fever	☐ Yes	☐ No
Chest pain upon exertion	☐ Yes	☐ No
Chronic pain	☐ Yes	☐ No
Disease, drug or radiation-induced immunosuppression	☐ Yes	☐ No
Type I Diabetes (insulin dependent)	☐ Yes	☐ No
Type II Diabetes	☐ Yes	☐ No
Dry Mouth	☐ Yes	☐ No
Abnormal bleeding	☐ Yes	☐ No
AIDS or HIV infection	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Osteoarthritis	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Rheumatoid arthritis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Blood transfusion: Date: _____	☐ Yes	☐ No
Cancer/Chemotherapy/Radiation Therapy	☐ Yes	☐ No

Cardiovascular disease:

Angina	☐ Yes	☐ No
Arteriosclerosis	☐ Yes	☐ No
Artificial heart valves	☐ Yes	☐ No
Congenital heart defects	☐ Yes	☐ No
Congestive heart failure	☐ Yes	☐ No
Coronary artery disease	☐ Yes	☐ No
Damaged heart valves	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Low blood pressure	☐ Yes	☐ No

Epilepsy, fainting spells or seizures	☐ Yes	☐ No
Gastrointestinal disease	☐ Yes	☐ No
GI Reflux/persistent heartburn	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Hepatitis, jaundice or liver disease	☐ Yes	☐ No
Kidney problems	☐ Yes	☐ No
Malnutrition	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Persistent swollen glands in neck	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Severe headache	☐ Yes	☐ No
Severe or rapid weight loss/weight gain	☐ Yes	☐ No
Sexually transmitted disease	☐ Yes	☐ No
Sinus trouble	☐ Yes	☐ No
Sleep disorder	☐ Yes	☐ No
Sores or ulcers in your mouth	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Systemic lupus erythematosus	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Thyroid problems	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Excessive urination	☐ Yes	☐ No
Eating Disorder	☐ Yes	☐ No

If yes, please specify:

_____

Do you use tobacco (smoking, snuff , chew)?	☐ Yes	☐ No
Do you drink alcoholic beverages?	☐ Yes	☐ No

If yes, how much alcohol did you drink in the past 24 hours?

_____

Are you alcohol or drug dependent?	☐ Yes	☐ No
If yes, have you received any treatment?	☐ Yes	☐ No
Do you use drugs or other substances for recreational?	☐ Yes	☐ No

If yes, please list:

_____

Frequency of use: _____

Number of years of recreational drug use: _____

Do you have any other disease, condition or problem not listed that you think we should know about?	☐ Yes	☐ No

If yes, please specify:

_____

Women only: Are you pregnant or nursing?	☐ Yes	☐ No
Women only: Are you taking oral contraceptives?	☐ Yes	☐ No

Do you have anxiety about dental treatment?	☐ Yes	☐ No
Do you feel claustrophobic during dental treatment?	☐ Yes	☐ No
Would you care to discuss using a sedative or laughing gas during your endodontic treatment?	☐ Yes	☐ No

Comments:

_____

Is there anything else that you would like for us to know about your health or preferences?	☐ Yes	☐ No

If yes, please specify:

_____

MUSIC

MUSIC: Name any ARTIST or GENRE of music that you would like for us to play during your treatment.

SIGNATURES

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omission that I may have made in completion of this form.

_____ _____ _____

Signature of Patient or Guardian | Print Name | Date

_____ _____

Signature of Dentist | Date

FINANCIAL RESPONSIBILITY

Patient's Full Legal Name: Nickname: Date: **04/20/2021**

Date of Birth: Age: ☐ M ☐ F Last 4 digits of SS#:

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RESPONSIBLE PARTY & PAYMENT METHOD

☐ I am the patient and I am the responsible party

☐ I am not the patient and I am the responsible party

☐ I am a self-pay patient and I plan to pay 100% today for a 10% discount

☐ I have dental insurance and I would like for you to file a claim on my behalf

☐ I subscribe to a discount plan that your office honors

☐ I am a self-pay patient and I am interested in a payment plan

RESPONSIBLE PARTY INFORMATION

Skip this Section if you are the Patient and the Responsible Pary

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☐ Personal Email Address:

Spouse's Full Legal Name:

Spouse's Occupation: Spouse's Employer:

☐ Mobile Phone (☐Call ☐Text ☐Both): ☐ Work Phone: ☐ Home Phone:

PRIMARY DENTAL INSURANCE

Insurance Company: Insured's Name:

Insured's Date of Birth: Group #/ Plan #: Id #:

Insurance Company Provider Phone #: Other:

Insurance Company Address:

SECONDARY DENTAL INSURANCE

You will need to file the claim for your secondary insurance coverage. You will be able to do so once you receive the Explanation of Benefits (EOB) from your primary insurance company for the claim filed. The secondary insurance company will pay you directly.

AUTHORIZATION

I understand that I am 100% responsible for the payment for treatment, even if my insurance does not pay. Mesquite Endodontics will involve a 3rd party collection agency or a small claims court for non-payment. Not upholding a payment plan agreement, cancelled credit cards, and NSF checks are the same as non-payment. .

_____ _____ _____

Signature Print Name Date

☐ I am interested in a payment plan agreement. My signature below authorizes the staff at the office to run my credit report to insure my qualification to make payments.

_____ _____ _____

Signature Print Name Date

RESET FORM SUBMIT FORM