

**Mesa Family Dental**  
Dental Registration and History

PATIENT INFORMATION	DENTAL INSURANCE
<p style="text-align: right;">Date _____</p> <p>Patient _____ Address _____ City _____ state _____ zip _____</p> <p>Gender <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birth Date _____</p> <p><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced</p> <p>Patient SS # _____</p> <p>Occupation _____</p> <p>Employer _____</p> <p>Employer Address _____</p> <p>Employer Phone _____</p> <p>Spouse's Name _____</p> <p>Spouse's SS # _____</p> <p>Birth Date _____</p> <p>Occupation _____</p> <p>Spouse's Employer _____</p> <p>Spouse's Name _____</p> <p>Whom may we thank for referring you? _____</p>	<p>Who is responsible for this account? _____</p> <p>Relationship to Patient _____</p> <p>Insurance Co. _____</p> <p>Group # _____</p> <p>Is Patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Subscriber's Name _____</p> <p>Subscriber's Birth Date _____</p> <p>Relationship to Patient _____</p> <p>Insurance Co. _____</p> <p>Group # _____</p> <p><b>Assignment And Release</b> I, the undersigned certify that I (or my dependent) have Insurance coverage with _____ and assign to Dr. Davoudi all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.</p> <hr/> <p style="text-align: center;">Signature _____ Date _____</p> <hr/> <p style="text-align: center;">Relationship to patient _____</p>

Phone Numbers
<p>Home _____ Work _____ Ext. _____ Spouse's Work _____</p> <p>Best time and place to reach you _____</p> <p><b>IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)</b></p> <p>Name _____ Relationship _____</p> <p>Home Phone _____ Work Phone _____</p>

Dental History		
<p>Reason for today's visit _____</p> <p>Former Dentist _____</p> <p>City/State _____</p> <p>Date of last dental visit _____</p> <p>Date of last dental X-Rays _____</p> <p>Place a mark on "Yes" or "No" to indicate if you have had any of the following</p> <p>Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mouth pain brushing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How often do you floss? _____</p> <p>How often do you brush? _____</p>

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PATIENT NAME \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_ Date of Birth \_\_\_\_\_

Circle the appropriate answer. If you don't know the correct answer, please write "don't know" on the line after the question.

	COMMENTS
1. Physician's Name _____ Address _____	
2. Are you under a physician's care ? ..... YES NO Since When _____ Why _____	
3. When was your last complete physical exam ? _____	
4. Are you taking any medication or substances ..... YES NO If YES, please list medications in the COMMENTS section ----->	
5. Do you routinely take health related substances? ..... YES NO	
6. Are you allergic to any medications or substances? ..... YES NO	
7. Do you have any other allergies? ..... YES NO	
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications?..... YES NO	
9. Are you sensitive to any metal or latex? ..... YES NO	
10. Are you pregnant or suspect you may be ? ..... YES NO	
11. Do you use any birth control medications? ..... YES NO	
12. Have you ever been treated for or been told you have heart disease ..... YES NO	
13. Do you have a pacemaker or an artificial heart valve implant? YES NO	
14. Have you ever had rheumatic fever? ..... YES NO	
15. Are you aware of any heart murmurs? ..... YES NO	
16. Do you have high or low blood pressure? ..... YES NO	
17. Have you ever had a serious illness or major surgery? ..... YES NO If so, explain _____	
18. Have ever had radiation treatment, chemo treatment, for tumor, growth, or other condition? ..... YES NO	
19. Do you have inflammatory diseases, such as arthritis or rheumatism? YES NO	
20. Do you have any artificial joints / prosthesis ..... YES NO	
21. Do you have any blood disorder such as anemia, leukemia, etc.? ... YES NO	
22. Have you ever bleed excessively after being cut or injured? ... YES NO	
23. Do you have any stomach problems? ..... YES NO	
24. Do you have any kidney problems? ..... YES NO	
25. Do you have any liver problems? ..... YES NO	
26. Are you diabetic? ..... YES NO	
27. Do you have asthma? ..... YES NO	
28. Do you have epilepsy or seizure disorders? ..... YES NO	
29. Do you or have you had venereal disease? ..... YES NO	
30. Have you tested HIV positive? ..... YES NO	
31. Do you have AIDS? ..... YES NO	
32. Have you had or do you test positive for hepatitis? ..... YES NO	
33. Do you or have you had T.B. ? ..... YES NO	
34. Do you smoke, chew, use snuff or any other form or tobacco? YES NO	
35. Do you consume alcoholic beverages? ..... YES NO	
36. Do you habitually use controlled substances? ..... YES NO	
37. Have you had psychiatric treatment? ..... YES NO	
38. Have you taken the prescription drugs fenfluramine combined with phen- termine (fen-fen), dexfenfluramine (redux) or other weight loss products? YES NO	
39. Do you have any disease, condition, or problem not listed? YES NO	
40. Is there anything else we should know about your health that we have not covered in this form? _____	
41. Would you like to speak to the Doctor privately about any problem? YES NO	

(Existing Patients Only) No changes have occurred in my medical history since two years ago.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT/GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

DENTIST'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_