Welcome to Mission Dental Care

We are complimented that you have selected us to provide dental care for you and your family. Please print and fill out all 4 pages, and sign the Consent For Treatment on Page 2 and the Medical History Form on Page 3.

PATIENT INFORMATION

Patient Name:_____**Date:**_____

If Child, Parent's Name:_____
Address:_____
City:_____**State:**_____**Zip:**_____
How Long at this address:_____
Home Phone:_____**Cell Phone**_____
Email:_____
Birthdate:_____**Social Security Number:**_____

Spouse Name:_____
Email:_____
Birthdate:_____**Social Security Number:**_____
Cell Phone_____

RESPONSIBLE PARTY/BILLING INFORMATION

Responsible Party Name:_____
Relationship to patient:_____
Address (if different from above):_____
City:_____**State:**_____**Zip:**_____
Home Phone:_____**Cell Phone**_____
Email:_____
Birthdate:_____**Social Security Number:**_____
Employer: _____**Occupation:**_____**Time here:**_____

Spouse Name:_____**Cell Phone:**_____
Email:_____
Birthdate:_____**Social Security Number:**_____

DENTAL INSURANCE, 1ST COVERAGE

Employee Name:_____**Relationship to patient:**_____
Birthdate:_____**Social Security Number:**_____
Employer:_____
Insurance Company Name:_____
Insurance Company Phone Number:_____
Subscriber ID Number:_____**Group Number:**_____

DENTAL INSURANCE, 2nd COVERAGE

Employee Name:_____**Relationship to patient:**_____
Birthdate:_____**Social Security Number:**_____
Employer:_____
Insurance Company Name:_____
Insurance Company Phone Number:_____
Subscriber ID Number:_____**Group Number:**_____

Patient Name:_____Date:_____

CONSENT FOR TREATMENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities of health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information.

Patient's or Guardian's signature:_____Date:_____

Patient Name:_____**Date:**_____

MEDICAL HISTORY

Who is your primary care physician?_____**Phone:**_____
Date of last physical:_____
Have you been hospitalized under a physician's care in the last two years? ☐Yes ☐No
If so, why?_____
Please list all medications/drugs you are taking:
_____
_____

Have you ever had an adverse reaction or allergies to any medication or substance? (Please check if allergic.)

☐Aspirin	**☐Codeine**	**☐Erythromycin**	**☐ Iodine**	**☐Latex**
☐Nitrous Oxide	**☐Novocaine**	**☐Penicillin**	**☐Sulfa Drugs**	**☐Tetracycline**
☐Valium	**☐Xylocaine**			

Others: _____

Have you ever had any of the following? (Please check all that apply)

☐Allergies	**☐Arthritis or Gout**	**☐Artificial Joint**
☐Asthma	**☐Bleeding Problem or Anemia**	**☐Blood Transfusion**
☐Blood disease	**☐Bruise Easily**	**☐Cancer**
☐Cold Sores	**☐Congenital Heart Problems**	**☐Currently Pregnant**
☐Diabetes	**☐Dizziness or Fainting**	**☐Drug/Alcohol Addiction**
☐Eating Disorder	**☐Emphysema**	**☐Epilepsy or Seizures**
☐Fever Blisters	**☐Frequent Thirst**	**☐Frequent Urination**
☐Glaucoma	**☐HIV-AIDS-ARC**	**☐Heart Attack or Stroke**
☐Heart Murmur	**☐Heart Trouble**	**☐Heart Valve or Pacemaker**
☐Hepatitis (A)	**☐Hepatitis (B)**	**☐Hepatitis (C)**
☐Herpes	**☐High Blood Pressure**	**☐Hypoglycemia**
☐Jaw Joint Pain	**☐Kidney or Liver Disease**	**☐Low Blood Pressure**
☐Lung Disease	**☐Psychiatric Care**	**☐Radiation/Chemotherapy**
☐Rheumatic Fever	**☐Sinus Problems**	**☐Thyroid Problems**
☐Tuberculosis	**☐Tumor or Growth**	**☐Ulcers or G.I. Problems**
☐Use Tobacco	**☐X-ray/Chemotherapy**	

Have you ever been given antibiotics before dental treatment?
☐Yes ☐No

Have you recently consumed alcohol?
☐Yes ☐No

Have you recently used recreational drugs?
☐Yes ☐No
Recreational use combined with local anesthesia may cause a life-threatening emergency.

Do you take or have you ever taken bisphosphonate therapy medications (commonly used to treat osteoporosis)?
☐Yes ☐No

Do you have any condition or problem not listed which we should know about? Please explain:
_____

I certify that the above information is complete and accurate.

Patient's or Guardian's signature:_____**Date:**_____

Doctor's signature:_____Date:_____

Patient Name:_____**Date:**_____

DENTAL HISTORY

What are your present dental concerns? _____
When was your last dental visit? _____**Dental x-rays?**_____
When was your last cleaning? _____
Have you avoided regular dental care?
☐**Yes** ☐**No**
Why? _____
Do you feel you have active decay?
☐**Yes** ☐**No**
Do you experience frequent bad breath?
☐**Yes** ☐**No**
Do you feel you have gum disease?
☐**Yes** ☐**No**
Have you ever had gum treatments?
☐**Yes** ☐**No**
How often do you brush? _____
Floss? _____
Use other aids? _____
Are you happy with the appearance of your teeth?
☐**Yes** ☐**No**
Would you like your teeth to be whiter?
☐**Yes** ☐**No**
What are your dental expectations? _____

Name of previous dentist: _____
City:_____**State:**_____
Have you lost any teeth or have any teeth been removed? ☐**Yes** ☐**No**
Why? _____

Have they been replaced?	☐**Yes**	☐**No**	
Replaced by a fixed bridge?	☐**Yes**	☐**No**	**Age?**
Replaced by a removable bridge?	☐**Yes**	☐**No**	**Age?**
Replaced by dentures?	☐**Yes**	☐**No**	**Age?**
Replaced by a dental implant?	☐**Yes**	☐**No**	**Age?**
Are you unhappy with the replacement?	☐**Yes**	☐**No**	

If yes, explain. _____
Would you like to know about permanent replacements? ☐**Yes** ☐**No**
Have you ever had any problems or complications with previous dental treatment?
☐**Yes** ☐**No**
If yes, explain. _____

Do you clench or grind your teeth?	☐**Yes**	☐**No**
Does your jaw click or pop?	☐**Yes**	☐**No**

Have you experienced any pain or soreness in the muscles of your face or around your ear?
☐**Yes** ☐**No**
Do you have frequent headaches, neck aches or shoulder aches?
☐**Yes** ☐**No**

Does food get caught in your teeth?	☐**Yes**	☐**No**

Are any of your teeth sensitive to:
☐**Hot** ☐**Cold** ☐**Sweets** ☐**Pressure**

Do your gums bleed or hurt?	☐**Yes**	☐**No**
If yes, when?		
Do you experience dry mouth?	☐**Yes**	☐**No**

Have you had any orthodontic work done? ☐**Yes** ☐**No**
Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
Do you have any specific questions or concerns? _____