Mona Lisa Dental

Patient Information

Patient Name: _____ **Date**: _____
Last, First MI (Preferred Name)
Gender (circle): Male / Female Marriage Status _____
Social Security #: _____ **Birth Date**: _____
Check Preferred Number to call
Phone (Home): _____ (Work): _____ (Cell): _____ □ Home □ Work □ Cell
Email Address: _____
Home Address: _____
Street City State Zip Code
Employer Name: _____ **Occupation**: _____
Employer Address: _____
Street City State Zip Code

Dental Information

Do you have a specific dental problem? Describe: _____
Do you have dental examinations on a routine basis? _____ Date of last visit: _____
Do you brush and floss on a routine basis? _____
Do you think you have active decay or gum disease? _____
Do your gums ever bleed? _____
Do you like your smile? Why? _____
Does food catch between your teeth? Do you have any loose teeth? _____
Do you want to keep your remaining teeth? _____
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____
Have your past experiences in the dental office always been positive? _____
Do you smoke ☐ chew ☐ vape ☐ use cannabis ☐ use Nicotine pouch ☐ consume alcohol ☐
Are there any sores or growths in your mouth? _____
Name of previous dentist? (Optional) _____
Date of your last full mouth x-rays? _____

Health Information

Have you ever had any of the following? Please check those that apply:

☐ Heart Trouble /Disease	☐ Blood Disease	☐ Emphysema	☐ Hepatitis A or B	☐ Stroke
☐ Heart Murmur	☐ Bruise easily	☐ Tuberculosis	☐ Kidney problems	☐ Epilepsy or Seizures
☐ Irregular Heart Beat	☐ Blood thinner Meds	☐ Cancer	☐ Renal Dialysis	☐ Fainting or Dizziness
☐ Angina / Chest Pain	☐ Excessive Bleeding	☐ Radiation Tx for cancer	☐ Thyroid/Parathyroid Disease	☐ Glaucoma
☐ Heart Attack / Failure	☐ Sickle Cell Disease	☐ Chemotherapy	☐ Arthritis / Gout	☐ Tumors or Growths
☐ Congenital Heart Disorder	☐ Hemophilia(Bleeding)	☐ Stomach/Intestinal Disease	☐ Rheumatism	☐ Nervousness / Anxiety
☐ Mitral Valve Prolapse	☐ Leukemia	☐ Ulcers	☐ Pain in jaw joint	☐ Psychiatric care
☐ Rheumatic Fever	☐ Blood Transfusion	☐ Recent weight loss	☐ Cortisone medications	☐ Alzheimer's Disease
☐ Artificial Heart Valve	☐ Swelling of limbs	☐ Frequent Diarrhea	☐ Artificial Joint	☐ Allergies to Medications
☐ Heart Pace Maker	☐ Lung Disease	☐ Diabetes	☐ Venereal disease	☐ Allergies Pollen / Dust
☐ Heart Surgery	☐ Frequent cough	☐ Excessive thirst	☐ AIDS / HIV +	☐ Hives or Rash
☐ High Blood Pressure	☐ Asthma / Hay Fever	☐ Hypoglycemia	☐ Drug Addiction	☐ Taking Medications
☐ Low Blood Pressure	☐ Pregnancy	☐ Liver Disease	☐ Cold sores/fever blisters	☐ Osteoporosis Meds

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been ever been hospitalized or had a major operation? ☐ Yes ☐ No Injury to head or neck? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- **Are you taking any medications, pills or drugs**? **List?** _____
- **Are you allergic to any medications or substances**? **Please check below:**
  ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex rubber ☐ Other _____
- **FOR WOMEN: Are you pregnant or trying to get pregnant?** ☐ Yes ☐ No
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ **Date**: _____
Signature of patient, parent or guardian

Spouse, Parent, Guardian Information or Emergency Contact

The following is for: ☐ the patient's spouse ☐ the patient's parent ☐ the patient's guardian ☐ Emergency Contact

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ **Birth Date**: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Home Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Referral Information

Whom may we thank for referring you to our practice? ☐ Website ☐ Insurance website ☐ Yellow Pages ☐ Drive by

☐ Facebook ☐ Catholic Sun ☐ Newspaper ☐ School ☐ Work ☐ Postcard in the mail ☐ Other: _____

☐ Another patient: Name of person or office referring you to our practice: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I authorized the Dentist and Staff to perform an examination, which may include x-rays. If diagnosed with prophy (regular cleaning), I authorize to have the procedure done as per the treatment plan presented.

All appointments not cancelled within 48 business hours prior to the appointment time are subject to a $25 missed appointment fee up to the first hour.

There is a $50 deposit due at time of scheduling for any appointment over 1 hour and will be non-refundable if a 48 business hours' notice to cancel is not provided.

I have read the above conditions of treatment and payment and agree to their content.

_____ **Date**: _____ **Relationship to Patient**: _____

Signature of patient, parent or guardian & Guarantor of payment/responsible party