Mosaic Dental

MOSAICDENTALVA.COM

Welcome to Mosaic Dental!

So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

Registration Form

Patient Information

Today's Date _____ Male _____ Female _____ Marital Status _____

Name _____ Date of Birth _____

Address _____ Apt. No. _____

City _____ State _____ Zip Code _____

Home Phone No. _____ Work Phone No. _____

Cell Phone/Pager _____ Email Address _____
(if you want to be contacted this way)

Social Security No. _____ Driver's License No. _____

Person to contact in case of emergency _____

Responsible Party

Name _____ Relationship to Patient _____

Address _____ City, State, Zip Code _____
(if different from above)

Home Phone No. _____ Work Phone No. _____

Social Security No. _____ Driver's License No. _____

Insurance Information

Employee Name _____ Employer Name _____

Insurance Co. _____ Group No. _____

Employee Date of Birth _____ Employee Social Security No. _____

Referred By:

Who may we thank for referring you to our office:

_____

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. I agree to the use of anesthetic, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that I shall be responsible for any and all expenses incurred at this office, and I understand that payment is due at the time of service unless other arrangements have been made, regardless if I have insurance. In the event payments are not received by agreed upon date, I understand that a 1.5% late charge (18% APR) and any expenses such as attorney fees if engaged for the purpose of collection may be added to my account.

Patient or Responsible Party _____ Date _____

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MEDICAL HISTORY

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Patient Name	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? ..... Yes ○ No ○
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs the past two years? ..... Yes ○ N ○

3. Are you taking any medication, drug or pills now? ..... Yes ○ No ○
   If yes, please list name and dosage _____

4. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? ..... Yes ○ No ○
   If yes, please list: _____

5. Have you been a patient in the hospital during that past five years? ..... Yes ○ No ○

6. Indicate which of the following you have ad, or have at present. Circle "yes" or "no" to each item.

Heart (surgery, disease, attack)	Yes ○	No ○	Ulcers	Yes ○	No ○	Hepatitis A (infectious) B (serum)	Yes ○	No ○
Chest Pain	Yes ○	No ○	Diabetes	Yes ○	No ○	Venereal Disease	Yes ○	No ○
Congenital Heart Disease	Yes ○	No ○	Thyroid Problems	Yes ○	No ○	A.I.D.S.	Yes ○	No ○
Heart Murmur	Yes ○	No ○	Glaucoma	Yes ○	No ○	H.I.V. Positive	Yes ○	No ○
High Blood Pressure	Yes ○	No ○	Contact lenses	Yes ○	No ○	Cold Sores/Fever Blisters	Yes ○	No ○
Mitral Valve Prolapse	Yes ○	No ○	Emphysema	Yes ○	No ○	Blood Transfusion	Yes ○	No ○
Artificial Heart Valve	Yes ○	No ○	Chronic Cough	Yes ○	No ○	Hemophilia	Yes ○	No ○
Heart Pacemaker	Yes ○	No ○	Tuberculosis	Yes ○	No ○	Sickle Cell Disease	Yes ○	No ○
Rheumatic Fever	Yes ○	No ○	Asthma	Yes ○	No ○	Bruise Easily	Yes ○	No ○
Arthritis/Rheumatism	Yes ○	No ○	Hay Fever	Yes ○	No ○	Liver Disease	Yes ○	No ○
Cortisone Medicine	Yes ○	No ○	Latex Sensitivity	Yes ○	No ○	Yellow Jaundice	Yes ○	No ○
Swollen Ankles	Yes ○	No ○	Allergies or Hives	Yes ○	No ○	Neurological Disorders	Yes ○	No ○
Stroke	Yes ○	No ○	Sinus Trouble	Yes ○	No ○	Epilepsy or Seizures	Yes ○	No ○
Diet (Special/Restricted)	Yes ○	No ○	Radiation Therapy	Yes ○	No ○	Fainting or Dizzy Spells	Yes ○	No ○
Artificial Joints (hip, knee, etc.)	Yes ○	No ○	Chemotherapy	Yes ○	No ○	Nervous/Anxious	Yes ○	No ○
Kidney Trouble	Yes ○	No ○	Tumors	Yes ○	No ○	Psychiatric/Psychological Care	Yes ○	No ○

7. Do you use more than two pillows to sleep? ..... Yes ○ No ○

8. Have you lost or gained more than 10 pounds in the past year? ..... Yes ○ No ○

9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes ○ No ○
   If yes, please list: _____

10. **Women** Are you: **Pregnant?** Yes, _____Months No **Nursing?** ☐Yes ☐No **Taking birth control pills?** Yes ☐No ☐

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

11. Patient/Guardian Signature _____ Date _____

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DENTAL HISTORY

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Patient Name	Medical Alert

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? ○ Yes ○ No

If yes, please describe: _____

Are any of your teeth sensitive to:
Hot or cold? ○ Yes ○ No
Sweets? ○ Yes ○ No
Biting or Chewing? ○ Yes ○ No
Have you noticed any mouth odors or bad taste? ○ Yes ○ No
Do you frequently get cold sores, blisters, or other oral lesions? ○ Yes ○ No

Do your gums bleed or hurt? ○ Yes ○ No
Have your parents experienced gum disease or tooth loss? ○ Yes ○ No
Have you noticed any loose teeth or change in your bite? ○ Yes ○ No
Does food tend to become caught between your teeth? ○ Yes ○ No
If yes, where? _____

Do you:
Clench or grind your teeth while awake or asleep? ○ Yes ○ No
Bite your lips or cheeks regularly? ○ Yes ○ No
Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)? ○ Yes ○ No
Mouth breathe while awake or asleep? ○ Yes ○ No
Have tired jaws, especially in the morning? ○ Yes ○ No
Smoke/chew tobacco? ○ Yes ○ No

Have you ever had:
Orthodontic treatment? ○ Yes ○ No
Oral surgery? ○ Yes ○ No
Periodontal treatment? ○ Yes ○ No
Your teeth ground or bite adjusted? ○ Yes ○ No
A bite plate or mouth guard? ○ Yes ○ No
A serious injury to the mouth or head? ○ Yes ○ No
If so, please describe, including cause _____

_____

Have you experience:
Clicking or popping of the jaw? ○ Yes ○ No
Pain (joint, ear, side of face)? ○ Yes ○ No
Difficulty in chewing on either side of the mouth? ○ Yes ○ No
Headaches, neckaches or shoulder aches? ○ Yes ○ No
Sore muscles (neck shoulders)? ○ Yes ○ No

Are you satisfied with your teeth's appearance? ○ Yes ○ No
Would you like to keep all of your teeth all of your life? ○ Yes ○ No
Do you feel nervous about having dental treatment? ○ Yes ○ No
If yes, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? ○ Yes ○ No
If yes, please describe _____

_____

Is there anything else about having dental treatment that you would like us to know? ○ Yes ○ No
If yes, please describe _____

_____

_____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Pratices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____ 20_____.

Print Patient Name _____

Signature _____

Relationship to Patient _____