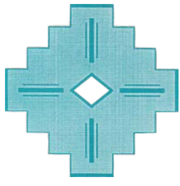


Lisa A. Lear, DDS, MSD

Diplomate American Board of Periodontology
Dental Implants & Periodontics

WELCOME

It is our goal is to help you reach a happy, healthy smile and maintain maximum oral health.

Please fill out this form completely.

Date: ____________________

Patient Information

Full Name: Prefer to be called:

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Birthdate: / / Age: SS #: Email:

Address:
STREET APT/CONDO # CITY STATE ZIP

Hm #: ( ) Cell #: ( ) Wk #: ( )

Where & when best times to reach you? Other family members seen by us?

Employer: Occupation:

Emp. Address:
STREET SUITE # CITY STATE ZIP

How long there? Whom may we Thank for referring you?

Current Dentist: Date of last visit: / / Previous Dentist:

Spouse or Parent Information

Name: Relationship: Birthdate: / / SS#:

Employer: Wk #: ( ) Cell #: ( )

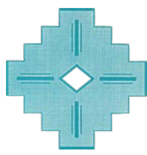
In the event of an emergency, is there someone who lives near you that we should contact?

Name: Relationship: Wk #: ( ) Hm / Cell #: ( )

Dental Insurance Coverage

Primary Dental Coverage	***Secondary Dental Coverage***
Ins. Co. Name:	Ins. Co. Name:
Ins. Co. Address:	Ins. Co. Address:
Ins. Co. Phone #: ( )	Ins. Co. Phone #: ( )
Group # (Plan, Local or Policy #):	Group # (Plan, Local or Policy #):
Subscriber Name:	Subscriber Name:
Birthdate: / / ID#:	Birthdate: / / ID#:
Relationship to patient:	Relationship to patient:
Subscriber Employer:	Subscriber Employer:

6367 E. Tanque Verde, Suite 210 ◦ Tucson, AZ 85715
Phone: (520) 577-3935 ◦ Fax: (520) 298-7112



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Name: ______________________________

Date: ________________

Dental History

Reason for today's visit?

Do you like your smile? Your current dental health is: ☐Good ☐Fair ☐Poor

Are you currently in pain? For how long?

Have you had a serious / difficult problem associated with previous dental work?

Please indicate any of the following problems by checking off the corresponding box: ☐**None**

☐Discomfort, clicking or popping in jaw	☐Lost/Broken filling(s)	☐Difficulty opening or closing jaw	☐Stained teeth
☐Red, swollen, or bleeding gums	☐Teeth grinding/clenching	☐Food catching between teeth	☐Locking jaw
☐Pus between teeth/gums when pressed	☐Ringing in ears	☐Loose/Shifting teeth	☐Bad breath
☐Blisters/Sores in or around mouth	☐Burning tongue/lips	☐Broken/Chipped tooth	☐Toothache
☐Change way teeth fit together when biting	☐Gum Disease	☐Swelling/Lumps in mouth	☐Missing teeth
☐Prolonged bleeding from injury/extraction	☐Receding gums	☐Recent infections or sore throat	☐Fit of denture

My teeth are sensitive to:
☐Hot ☐Cold
☐Sweets ☐Biting

How often do you?
Brush:_____________ Waterpik:_____________
Floss: _____________

Toothbrush type:
☐Electric ☐Manual
☐Soft ☐Medium ☐Hard

Medical History

Have you ever been instructed to take antibiotics prior to dental procedures?

Are you in good health? Height: Weight: Are you under the care of a physician?

Physician's Name: Phone #: ( )

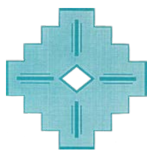
Address: Date of last visit: / /

Do you smoke or use tobacco? Type: How much: How long:

List any history of serious medical condition(s):

Do you have, or have you had, any of the following diseases, medical conditions, or procedures? ☐**None**

☐Rheumatic/Scarlet Fever	☐Sickle Cell disease / traits	☐Diabetes	☐Kidney Problems
☐Mitral Valve Prolapse	☐Osteoporosis / Osteopenia	☐Immune system problems	☐Are you on dialysis?
☐Heart Murmur	☐Osteonecrosis	☐Liver disease / Cirrhosis	☐Arthritis / Joint disease
☐Hepatitis	☐Heart Surgery / Prosthetic valve	☐High Blood Pressure	☐Snoring / Sleep Apnea
☐Infectious Mononucleosis	☐Damaged heart valves	☐Low Blood Pressure	☐Psychiatric Treatment
☐Herpes / Fever blisters	☐Congenital heart defect	☐Chest pain / Angina	☐Tuberculosis (TB)
☐Seizures	☐Heart attack(s)	☐Emphysema	☐Fainting spells
☐Epilepsy	☐Irregular heartbeat	☐Colitis	☐Anemia
☐Shingles	☐Cardiac pacemaker	☐Stomach Ulcers	☐Stroke
☐Alcohol / Drug abuse	☐Blood transfusion	☐Thyroid problems	☐Bruise easily
☐Eye disease / Glaucoma	☐Bleeding tendency / Hemophilia	☐Swollen ankles	☐Abnormal bleeding
☐Asthma	☐Cancer/Radiation/Chemotherapy	☐Are you on a diet?	☐Venereal disease
☐Hay fever / Sinus problems	☐Artificial knee or hip joint	☐Frequent headaches	☐HIV / AIDS



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Name: ______________________________

Date: ____________________

Medications & Allergies

Are you taking, have you ever taken the following? ☐None

☐Pain killers (including aspirin) ☐Muscle relaxers ☐Stimulants ☐Tranquilizers ☐Insulin ☐Antidepressants

☐Any bone density medication / injection (Actonel, Aredia, Boniva, Didronel, Fosamax, Prolia, Reclast, Zometa)

☐Blood Thinners (Advil, Aspirin, Coumadin, Plavix, Eliquis, Pradaxa, Xarelto)

List any other medication(s) you are taking (including natural, herbal or homeopathic products):

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Are you allergic to, or had a reaction to the following? ☐I have no known allergies

☐Penicillin / Amoxicillin ☐Aspirin ☐Dental Anesthetics (numbing med) ☐Latex

☐Clindamycin ☐Ibuprofen / Naproxen ☐Sulfites

☐Tetracycline ☐Codeine or other narcotics ☐Jewelry

☐Erythromycin ☐Valium or other tranquilizers ☐Metals

List any other medications or antibiotics you are allergic to:		List any other allergies other than drug allergies:	

List any medication(s) you have been told not to take and the explanation:

____

Healthcare Specialists / Dental Specialists

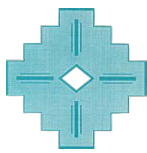
Name	Phone	Condition / Treatment
	( )	
	( )	
	( )	
	( )	
	( )	
	( )	

For Women

Are you pregnant? ☐Yes ☐No If Yes, # of weeks: Are you nursing? ☐Yes ☐No

Are you using a prescribed method of birth control? ☐Yes ☐No

(Note: Antibiotics may alter effectiveness of birth control pills. Consult your physician for assistance regarding additional birth control methods.)



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Name: ______________________________

Date: ____________________

General Authorization & Financial Consent

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any about the inquiries set forth above have been answered to my satisfaction. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I will not hold my doctor, or any member of his/her staff, responsible for any errors or omissions that I have made in the questionnaire above.

I authorize the doctor and dental staff to perform any necessary dental services that is needed during diagnosis and treatment with my informed consent.

I authorize the office of Dr. Lear to release any information including diagnosis and records of treatment of examination for myself and my dependent(s) to third party insurance carriers, payors, and health-care providers.

I grant my permission to telephone me or the listed people below at home, work, or cell phone to discuss matters related to this consent, my treatment, or my account. If your contact preferences change, you must provide us written notice of revocation.

Name:	Relationship:	Phone #: ( )
Name:	Relationship:	Phone #: ( )

I understand that I am financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any). This dental office cannot render services on the assumption that our fees will be paid by an insurance company. As a courtesy, we will file your insurance claims and have your insurance company reimburse you directly. In the event of legal action on this account, I agree to pay any and all costs of such suit, collection and attorney fees.

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

Signature of patient (Guardian, Representative or Parent if Minor) Date

I give permission for any photos of my mouth taken by the office of Dr. Lear to be used for educational and promotional purposes.

Signature of patient (Guardian, Representative or Parent if Minor) Date

Insurance Authorization

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. The signature on file is my authorization for the release of information necessary to process my claim.

Signature of patient (Guardian, Representative or Parent if Minor) Date

HIPAA Acknowledgement

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me and I may ask for a copy to take with me at any time. I have been given the opportunity to ask questions I may have now or in the future regarding the Notice.

Signature of patient (Guardian, Representative or Parent if Minor) Date

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and ADA.

DOCTOR USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: Date:

Doctor's Comments:

FORM DMH2023

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