MANSFIELD DENTAL ASSOCIATES, PA
1700 Country Club Drive
Mansfield, TX 76063
Phone 817-473-6227
Fax 817-473-6919
www.mansfielddental.com

MEDICAL HISTORY

Patient name _____ Preferred name _____
(First) (MI) (Last)

Birth date _____

Are you under a physician's care now? ❑ Yes ❑ No If yes, please explain: _____

Have you recently been hospitalized or had an operation? ❑ Yes ❑ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ❑ Yes ❑ No If yes, please explain: _____

Medication being taken now (including non prescription) _____

_____

Name and phone number of your physician (s) _____

_____

_____

Women: Are you

❑ Pregnant/Trying to get pregnant? ❑ Nursing?
❑ Taking oral contraceptives?

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Dental Anesthetics
❑ Tylenol ❑ Erythromycin ❑ Tetracycline ❑ Other

Do you have or have you had any of the following?

❑ AIDS/HIV Positive
❑ Alzheimer's Disease
❑ Anaphylactic reaction
❑ Anemia
❑ Angina
❑ Arthritis
❑ Artificial Heart Valve
❑ Artificial Joints
❑ Asthma
❑ Atrial Fibrillation
❑ Blood Disease
❑ Blood Transfusion
❑ Breathing Problem
❑ Bruise Easily
❑ Cancer _____
❑ Chemotherapy
❑ Chest Pains
❑ Cold Sores/Fever Blisters
❑ Congenital Heart Disorder
❑ Convulsions
❑ Cortisone Medicine
❑ Diabetes
❑ Drug Addiction
❑ Eating Disorder
❑ Emphysema
❑ Endocarditis
❑ Epilepsy or Seizures
❑ Excessive Bleeding
❑ Fainting Spells/Dizziness
❑ Frequent Headaches
❑ Gastric Reflux
❑ Glaucoma
❑ Gout
❑ Heart Attack/Failure
❑ Heart Murmur
❑ Heart Pace Maker
❑ Heart Trouble/Disease
❑ Hemophilia
❑ Hepatitis A
❑ Hepatitis B
❑ Hepatitis C
❑ High Blood Pressure
❑ Hypoglycemia
❑ Irregular Heartbeat
❑ Kidney Problems
❑ Liver Disease
❑ Low Blood Pressure
❑ Lung Disease
❑ Mitral Valve Prolapse
❑ Organ Transplant
❑ Osteoporosis
❑ Radiation Treatments
❑ Renal Dialysis
❑ Shingles
❑ Sickle Cell Disease
❑ Sinus Trouble
❑ Snoring
❑ Sleep Apnea
❑ Stomach/Intestinal Disorders
❑ Stroke
❑ Thyroid Disease
❑ Tobacco Use
❑ Tuberculosis
❑ Ulcers

Have you ever had any serious illness not listed above? ❑ Yes ❑ No If yes, please explain: _____

Comments: _____

_____

_____

_____

I hereby authorize this dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. All information on this page is correct to the best of my knowledge.

Signature of patient, parent or guardian _____ Date _____

I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am responsible for all costs for dental treatment. Accounts more than 30 days past due may be subject to a service charge of 1.5% per month (or a minimum charge of $2.00).

Signature of patient, parent or guardian _____ Date _____

We appreciate the opportunity to provide your dental care. Our goal is to provide you with the highest quality of dental services available. Please feel free to ask any questions you may have with regard to your dental treatment or our office procedures. This office meets or exceeds all infection control procedures recommended by the Center for Disease Control, the American Dental Association and OSHA.

PATIENT INFORMATION

Name _____
(First) (MI) (Last)

Address _____ City _____ State _____ Zip _____

Home phone _____ Business phone _____ May we call you at work? ❑ Yes ❑ No

Cell phone _____ E-mail _____ Date of birth _____

Employed by _____ Occupation _____

Social Security number _____ Driver's license number _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Spouse's name _____ Employed by _____

Children's name(s) _____

Are any other members of your family a patient in this office? _____

Whom may we thank for referring you? _____

Financially responsible person for this patient _____ Relationship to patient _____

Address (if different from above) _____

Home phone _____ Cell phone _____ DL# _____

If you have dental insurance, please complete the following:

Name of dental insurance co. _____

Policy # _____

Name of insured employee _____

Date of birth of insured employee_____

Social Security number of insured employee_____

DENTAL HISTORY

Date of last dental visit _____ Date of last dental cleaning _____

Name of previous dentist _____

Are you currently having any dental problems? ❑ Yes ❑ No Reason for today's visit _____

Have you had any problems or complications with previous dental treatment? ❑ Yes ❑ No If yes, describe briefly _____

_____

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

Have you ever been treated for periodontal (gum) disease? ❑ Yes ❑ No Do your gums bleed when you brush? ❑ Yes ❑ No

Do you have frequent headaches? ❑ Yes ❑ No Do you grind or clench your teeth? ❑ Yes ❑ No

Do your ever have popping, clicking or pain in your jaw joint (TMJ)? ❑ Yes ❑ No

Have you ever had braces? ❑ Yes ❑ No Do you smoke? ❑ Yes ❑ No Do you use smokeless tobacco? ❑ Yes ❑ No

Is there anything you would like to change about your teeth or your smile? ❑ Yes ❑ No If yes, explain briefly _____

_____

Submit