MANSFIELD DENTAL ASSOCIATES, PA
1700 Country Club Drive
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Phone 817-473-6227
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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 ______________________

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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 ______________________

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