



MANSFIELD DENTAL ASSOCIATES
 1700 Country Club Drive
 Mansfield, TX 76063
 Phone 817-473-6227
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ADULT MEDICAL HISTORY
PLEASE COMPLETE BOTH SIDES OF THIS FORM.

Patient name _____ I prefer to be called _____
 (First) (MI) (Last)

MEDICAL HISTORY: Do you have a past or present history of:

- | Yes | No | Don't Know | Yes | No | Don't Know | Yes | No | Don't Know | | | |
|--------------------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High or low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy, seizures or fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Radiation therapy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Artificial heart valves | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | AIDS or HIV Positive | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart disease or heart surgery | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Congenital heart defects | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Liver or kidney problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinus problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cortisone therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mitral valve prolapse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma, bronchitis or emphysema | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Artificial joints (hip, knee, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Organ transplant |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding problems or disorders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| | | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | | | | |

Notes _____

Name of your physician _____

Are you under the care of a physician now? Yes No If yes, describe briefly _____

Have you been hospitalized or had a major operation In the past 5 years? Yes No

If yes, describe briefly _____

Medications being taken now (including non prescription medications) _____

Have you ever taken the medications Fen-Phen, Redux, or Pondimen? Yes No

Are you allergic to any of the following medications or substances?

Latex Aspirin Tylenol Codeine Penicillin Erythromycin Tetracycline Dental anesthetic Other _____

Are you pregnant or think you might be? Yes No Due date _____

Are there any other medical conditions of which we should be aware? _____

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. The information on this page and the dental/medical histories are correct to the best of my knowledge.

I DO/ DO NOT 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 _____ 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

PLEASE COMPLETE BOTH SIDES OF THIS FORM.

Name _____
(First) (MI) (Last)

Address _____ City _____ State _____ Zip _____

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

Cell phone or pager _____ 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? _____

If you have dental insurance, please complete the following:

PRIMARY INSURANCE

SECONDARY INSURANCE

Name of primary insurance co. _____

Name of secondary insurance co. _____

Policy # _____

Policy # _____

Name of insured employee _____

Name of insured employee _____

Date of birth _____

Date of birth _____

Social Security number _____

Social Security number _____

DENTAL HISTORY

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

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 floss your teeth? _____ Do your gums bleed when you brush? Yes No

Have you ever been treated for periodontal (gum) disease? Yes No Do you grind or clench your teeth? Yes No

Do you have frequent headaches? Yes No Do you 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 _____
