MANSFIELD DENTAL CENTER

Patient Medical History

Name: _____ Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.
We appreciate and thank you for answering the following questions.

Are you under a physician's care now? Yes ☐ No ☐ If Yes, please specify: _____
Have you ever been hospitalized or had a major operation? Yes ☐ No ☐ If Yes, please specify: _____
Have you ever has a serious head or neck injury? Yes ☐ No ☐ If yes, please specify: _____
Are you taking any medications, pills, drugs? Yes ☐ No ☐ If yes, please specify: _____
Do you use tobacco? Yes ☐ No ☐ If yes, please specify: _____
Do you have any history of alcohol or drug dependency? Yes ☐ No ☐ If yes, please specify: _____
Do you use controlled substance? Yes ☐ No ☐ If yes, please specify: _____
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? Yes ☐ No ☐

Women: **Are you pregnant or trying to get pregnant?** Yes ☐ No ☐ **Taking Oral Contraceptives?** Yes ☐ No ☐ **Nursing?** Yes ☐ No ☐

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local anesthetics ☐ Latex ☐ Sulfa Drugs
☐ Other If yes, explain: _____

Do you have any of the following?

AIDS/HIV positive	Yes ☐ No ☐	**Diabetes**	Yes ☐ No ☐	**Hepatitis A, B, or C**	Yes ☐ No ☐	**please specify which one**: _____					
High Blood Pressure	Yes ☐ No ☐	**Low Blood Pressure**	Yes ☐ No ☐	**Artificial Heart Valve**	Yes ☐ No ☐	**Artificial joint**	Yes ☐ No ☐				
Pace Maker	Yes ☐ No ☐	**Asthma**	Yes ☐ No ☐	**Kidney Problems**	Yes ☐ No ☐	**Cancer**	Yes ☐ No ☐				
Chemotherapy	Yes ☐ No ☐	**Heart Attack**	Yes ☐ No ☐	**Heart Problems**	Yes ☐ No ☐	**Stroke**	Yes ☐ No ☐				
Epilepsy or Seizures	Yes ☐ No ☐	**Thyroid Problems**	Yes ☐ No ☐	**Blood Thinners**	Yes ☐ No ☐	**Cold Sores**	Yes ☐ No ☐				

Do you have any other serious illnesses that are not listed? Yes ☐ No ☐ If yes, please explain: _____

Are you required to Pre-Medicate with antibiotics before dental treatment? Yes ☐ No ☐
Do you consume grapefruit, grapefruit juice, or grapefruit extract? Yes ☐ No ☐

Please list any prescription medications and or any supplements that you are currently taking:

_____
_____
_____
_____
_____
_____

We invite you to discuss with us any questions regarding our services. The best Dental Health services are based on a friendly, mutual understanding between provider and patient.

- Our policy requires the payment in full, at the time services are rendered, unless other arrangements have been made. If account is not paid within 45 days of the date of service and no financial arrangements have been made, you will be responsible for collection agency fees, interest charges and any other expenses incurred in collection of you account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information, and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information I have provided.
- 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.

Print Name: _____ ***Signature*:** _____ **Date:** _____
☐ Adult Patient ☐ Parent/Guardian ☐ Spouse