Mansfield CT Dental

Name:_____________________________

Date of Birth:________________________ **Date:**________________________

MEDICAL HISTORY

Are you in general good health at this time? **YES NO**

Name of Physician (Primary/Cardiologist/Orthopedist)____

Physician's phone number____

Please list any major operations, heart surgery, or joint replacements _______________________________________

Please list any adverse reactions to any medications. ____

Please list any **allergies**.____

Have you ever needed to premedicate for your dental appointments? **YES NO**

Health Conditions: (*Please indicate if you have any of the following conditions by circling yes or no*)

Arthritis or Rheumatism	**YES**	**NO**	Low Blood Pressure	**YES**	**NO**
Blood Disease	**YES**	**NO**	Organ Transplant	**YES**	**NO**
Diabetes	**YES**	**NO**	Prolonged bleeding after Extraction	**YES**	**NO**
Do you smoke or use smokeless Tobacco	**YES**	**NO**	Respiratory disease (COPD/Asthma)	**YES**	**NO**
Glaucoma	**YES**	**NO**	Slow healing wounds	**YES**	**NO**
Heart Ailments (including artificial valves)	**YES**	**NO**	Stomach or Intestinal Disorder	**YES**	**NO**
High Blood Pressure	**YES**	**NO**	Tuberculosis	**YES**	**NO**
History of Fainting	**YES**	**NO**	Tumors or growths	**YES**	**NO**
HIV or Aids	**YES**	**NO**	Venereal Disease or STD	**YES**	**NO**
Liver or kidney Disease (Hepatitis/Jaundice)	**YES**	**NO**	For Women: Are you pregnant at this time?	**YES**	**NO**
Other, please specify:	**YES**	**NO**			

Are you taking any drugs or medications at this time? If yes, please list below.	

Dental History

Do you have pain near your ears?	**YES**	**NO**	Have you had oral growths or sores?	**YES**	**NO**
Do you clench and/or grind your teeth?	**YES**	**NO**	Are you happy with the look of your teeth?	**YES**	**NO**
Do your gums bleed?	**YES**	**NO**	Do you have a problem with your teeth or gums?	**YES**	**NO**

Date of last dental visit:________________________

I confirm that I have entered the above information accurately and to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I consent to any and all dental treatments recommended to maintain my oral health. I authorize and request my dental insurance company to pay directly to the dentist. I understand my dental benefits and am aware that I am responsible for payment of any and all services not covered by dental insurance. I understand that I am responsible for payment of all services rendered on my behalf and on the behalf of my dependants.

Signature____ **Date:**_____________