WELCOME TO MANGAT FAMILY DENTISTRY

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out the form completely. If you have any questions, please ask us- we will be happy to help.

Patient Information

Today's Date _____

Name_____ Nickname _____ DOB_____

SSN *_____ (*used solely for looking up insurance coverage)

Sex _____ Address_____

City, State, Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Check Appropriate __ Single __ Married __ Divorced __ Widowed __ Separated __ Other

Referred to our office by _____

Medical History

General Health ___ Good ___ Fair ___ Poor

Physician _____ Office Phone _____

Date of Last Exam _____

Are you currently on any prescription or over the counter medications, vitamins, nutrients, or herbal vitamins? ____ Yes ____No

If yes, please list ALL MEDICATIONS and their purpose. If you have a list of medications, we will gladly make a copy for you for your file.

_____ _____ (more space next page)

_____ _____

_____ _____

Are you allergic to any medications?

___ Yes ___ No

___ Penicillin ___ Dental Anesthetics ___ Latex

___ Aspirin ___ Codeine ____ Other

Please list any other drugs that you are allergic to _____

Do you require antibiotic coverage prior to dental appointments? ___ Yes ___ No

Are you taking birth control pills? ___ Yes ___ No

Are you pregnant? ___ Yes ___ No Week # _____

Are you nursing? ____ Yes ___ No

Do you have an artificial joint replacement or implant? ____ Yes ____ No

If yes, when was it placed? _____

Do you use or have you used tobacco products? ___ Yes ___ No

Please circle Y or N for each individual question below

Y N High Blood Pressure	**Y N Heart Disease**	**Y N Osteoporosis**
Y N Heart Attack	**Y N Pacemaker**	**Y N Chest Pains**
Y N Rheumatic Fever	**Y N Heart Murmur**	**Y N Steroids**
Y N Swollen Ankles	**Y N Artificial Heart Valves**	**Y N Scarlet Fever**
Y N Fainting/ Seizures	**Y N Frequently Tired**	**Y N Tuberculosis**
Y N Asthma	**Y N Anemia**	**Y N Glaucoma**
Y N Epilepsy/ Convulsions	**Y N Emphysema**	**Y N Liver Disease**
Y N Leukemia	**Y N Cancer Type _____**	**Y N Hemophilia**
Y N Abnormal Bleeding	**Y N Diabetes Type __ H1ac__**	**Y N Arthritis**
Y N Respiratory Problems	**Y N Kidney Disease**	**Y N Hepatitis**

Y N Mitral Valve Prolapse **Y N HIV/ AIDS** **Y N Drug Abuse**

Y N Alcohol Abuse **Y N Eating Disorders** **Y N Stomach Ulcer**

Do you have any other medical condition that is not listed? Y N (If Yes, please list):

Dental History

Name of previous dentist _____ Last Dental Visit _____

Why have you come to the dentist today? _____

Are you currently in pain? Y N

Do you now or have you ever experienced pain or discomfort in our jaw joint? Y N

Your current dental health is: __ Good __ Fair __ Poor

How often do you get dental cleanings? _____

How many times a week do you floss? _____

How many times a week do you brush? _____

I understand that the information that I have given today is correct and to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____ Signature _____ Date