PATIENT MEDICAL DENTAL HISTORY

1. Are you having pain or discomfort at this time? YES NO

2. Have you ever been hospitalized? YES NO
   Please list most recent surgeries _____
   _____

3. Have you been the recipient of any artificial organs, joints, or valves? YES NO

4. Have you been under the care of a medical doctor during the past two years? YES NO
   Physician's Name: _____
   Address: _____ Telephone: _____

5. Have you taken any medications or drugs during the past two years? YES NO
6. Are you now taking any medication? If so, please list: _____ YES NO
   _____

7. Are you aware of being allergic to or have you ever reacted adversely to any medication? YES NO
   If yes, please list: _____
   _____

8. Please indicate by check which of the following you have had or have at present.

☐ Heart Failure	☐ Stroke	☐ Hepatitis A (infectious)	☐ Rheumatism
☐ Heart Disease or Attack	☐ Artificial Joints	☐ Hepatitis B (serum)	☐ Pain in Jaw Joints
☐ Angina Pectoris	☐ Kidney Trouble	☐ Venereal Disease	☐ Cortisone Medicine
☐ Congenital Heart Disease	☐ Ulcers	☐ A.I.D.S.	☐ Drug Addiction
☐ Heart Murmur	☐ Diabetes	☐ H.I.V. Positive	☐ Allergies or Hives
☐ High Blood Pressure	☐ Thyroid Problems	☐ Cold Sores / Fever Blisters	☐ Sinus Trouble
☐ Arteriosclerosis	☐ Glaucoma	☐ Blood Transfusion	☐ Radiation Therapy
☐ Mitral Valve Prolapse	☐ Cosmetic Surgery	☐ Hemophilia	☐ Chemotherapy
☐ Artificial Heart Valve	☐ Emphysema	☐ Anemia	☐ Epilepsy or Seizures
☐ Heart Pacemaker	☐ Chronic Cough	☐ Sickle Cell Disease	☐ Fainting or Dizzy Spells
☐ Heart Surgery	☐ Tuberculosis	☐ Bruise Easily	☐ Nervousness
☐ Rheumatic Fever	☐ Asthma	☐ Liver Disease	☐ Psychiatric Treatment
☐ Arthritis	☐ Hay Fever	☐ Yellow Jaundice	

9. Have you ever taken Phen-fen or similar appetite suppressants? YES NO
   If yes, have you seen your physician or cardiologist for a cardiac evaluation? YES NO

10. Do you smoke? YES NO
    How many years _____ Packs per day _____

11. Do you drink alcoholic beverages? YES NO
    Average drinks per week _____

12. Do you experience pain in your chest, shortness of breath, or feel very tired? YES NO

13. Do your ankles swell during the day? YES NO
14. Have you lost or gained more than 10 pounds in the past year? YES NO
15. Has your medical doctor ever said you have cancer or a tumor? YES NO
16. Do you have or have you had any disease, condition, or problem not listed? YES NO
    If yes, please list: _____
17. Has your physician ever recommended that you be premedicated with antibiotics before any dental treatment? YES NO

FOR WOMEN ONLY:
Are you pregnant? ☐ YES, what month? _____ ☐ NO Are you nursing? ☐ YES ☐ NO
Are you taking birth control pills? ☐ YES ☐ NO

I understand the above information is necessary to provide me with periodontal care in a safe and efficient manner.
I have answered all questions truthfully and to the best of my knowledge.

Patient Signature: _____ Date: _____

Please Print Name: _____

Patient Information

Date _____ Responsible Party Social Security # _____

Responsible Party _____ Telephone _____ / _____ / _____
Home Mobile Email

Patient Name _____ Telephone _____/ _____/ _____
Home Mobile Email

Patient Date of Birth _____ Age _____ Sex _____ Marital Status _____

Address _____ City _____ Sate _____ Zip _____

Employer Name and Address _____

Occupation _____

In case of emergency Contact: Name, Address and Phone Number of relative or friend: _____
_____

Name of Referring Dentist _____

Office Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered. Payment is due on your initial consultation (first visit), as well as your periodontal maintenance and any insurance reimbursement will be directed to the patient.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding 45 days from the date of service unless previously written financial arrangements are satisfied. I understand that the fee estimates listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, therefore the reasonable value of said services to said dentist or his assignee at the time of said services are rendered, or within thirty (30) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder to collect monies owed by me, including charges or commissions up to 50% that may be assessed to us by any collection agency retained to pursue this matter.

I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Mark L. Mangelson DDS, MS, PC.

I certify that I have answered all questions on this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined hereon.

Signature of patient	**Date**	**Signature of responsible party other than patient**	**Relationship**	**Date**