Marina Bay DENTAL ASSOCIATES

308 Victory Road
Quincy, MA 02171
P: 617-479-8080 F: 617-479-8189

Patient Name:	
Primary Physician's Name (PCP):	
Physician's Address:	Physician's Phone:

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive.

What year was your last physical **20_____ ☐?**

Are you under a physician's care? (Other than yearly checkups) ☐Y ☐N **Explain**: _____

Are you pregnant or trying to get pregnant? ☐Y ☐N Taking oral contraceptives ☐Y ☐N Nursing ☐Y ☐N

Do you consume alcoholic beverages? ☐Y ☐N **Explain/How often**: _____

Do you use: ☐Cigarettes ☐Chewing tobacco ☐Nicotine (JUUL, vapes, e-cigs, hookah)
☐Marijuana ☐ Illegal Substances ☐**Other:** _____

Are you allergic to: ☐Anesthetics ☐Antibiotics ☐Latex ☐Metals ☐**Other**: _____

Have you ever been told to pre-medicate before dental appointments ☐Y ☐N **Explain**: _____

Do you have any artificial joints? ☐ Hip ☐ Knee ☐ **Other:**_____ **Date of Replacement:**_____

List any and all medications or herbal supplements you are taking:

Do you have or have you had: (check all that apply, and explain as necessary in line below)

☐AIDS/HIV	☐Chemotherapy	☐Hepatitis	☐Pacemaker
☐Alzheimer's Disease	☐Congenital Heart Disease	☐High Cholesterol	☐Radiation Treatment
☐Anaphylaxis	☐Diabetes	☐High Blood Pressure	☐Rheumatic Fever
☐Anemia	☐Drug Addiction	☐Hives or Rash	☐Rheumatism
☐Arthritis	☐Epilepsy or seizure disorders	☐Irregular Heartbeat	☐Sickle Cell Disease
☐Artificial heart valve implant	☐Gastrointestinal Problems	☐Kidney Problems	☐Stroke
☐Artificial joints or prosthesis	☐Glaucoma	☐Liver Disease	☐Thyroid Disease
☐Asthma	☐Heart Disease	☐Lung Disease	☐Tumors or Growths
☐Bleeding disorders	☐Heart Murmurs	☐Major Surgery	☐TB
☐Cancer	☐Hemophilia	☐Mental Health Conditions	☐Ulcers

Do you have any other disease, condition, serious illness, or other problem about your health that we should know about? ☐Y☐N

Explain: _____

Other Comments:

I certify that the above information is complete and accurate.

Patient/Guardian Signature: _____ Date _____ Provider Signature: _____Date_____

MEDICAL HISTORY * YEAR 20_____