MYSTIC DENTAL GROUP
A PROFESSIONAL CORPORATION

Medical History

PATIENT NAME _____

Are you under a physician's care now? ❍ Yes ❍ No _____

Have you ever been hospitalized or had a major operation? ❍ Yes ❍ No _____

Have you ever had a serious head or neck injury? ❍ Yes ❍ No _____

Are you taking any medications, pills, or drugs? ❍ Yes ❍ No _____

Do you take, or have you taken, Phen-Fen or Redux? ❍ Yes ❍ No Do you use tobacco? ❍ Yes ❍ No

Are you on a special diet? ❍ Yes ❍ No Do you use controlled substances? ❍ Yes ❍ No

Women: Are you ❑ Pregnant/Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following?
❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Other _____

Do you have, or have you had, any of the following?

❑ AIDS/ HIV Positive	❑ Cold Sores/Fever Blisters	❑ Glaucoma	❑ Leukemia	❑ Sickle Cell Disease
❑ Alzheimer's Disease	❑ Congenital Heart Disorder	❑ Hay Fever	❑ Liver Disease	❑ Sinus Trouble
❑ Anaphylaxis	❑ Convulsions	❑ Heart Attack/Failure	❑ Low Blood Pressure	❑ Spina Bifida
❑ Anemia	❑ Cortisone Medicine	❑ Heart Murmur*	❑ Lung Disease	❑ Stomach/Intestinal Disease
❑ Angina	❑ Diabetes	❑ Heart Pace Maker*	❑ Mitral Valve Prolapse*	❑ Stroke
❑ Arthritis/Gout	❑ Drug Addiction	❑ Heart Trouble/Disease	❑ Pain in Jaw Joints	❑ Swelling of Limbs
❑ Artificial Heart Valve*	❑ Easily Winded	❑ Hemophilia	❑ Parathyroid Disease	❑ Thyroid Disease
❑ Artificial Joint*	❑ Emphysema	❑ Hepatitis A	❑ Psychiatric Care	❑ Tonsillitis
❑ Asthma	❑ Epilepsy or Seizures	❑ Hepatitis B or C	❑ Radiation Treatments	❑ Tuberculosis
❑ Blood Disease	❑ Excessive Bleeding	❑ Herpes	❑ Recent Weight Loss	❑ Tumors or Growths
❑ Blood Transfusion	❑ Excessive Thirst	❑ High Blood Pressure	❑ Renal Dialysis	❑ Venereal Disease
❑ Breathing Problem	❑ Fainting Spells/Dizziness	❑ Hive or Rash	❑ Rheumatic Fever*	❑ Yellow Jaundice
❑ Bruise Easily	❑ Frequent Cough	❑ Hypoglycemia	❑ Rheumatism	❑ High Cholesterol
❑ Cancer	❑ Frequent Diarrhea	❑ Irregular Heartbeat	❑ Scarlet Fever	❑ Dialysis
❑ Chemotherapy	❑ Frequent Headaches	❑ Kidney Problems	❑ Shingles	
❑ Chest Pains	❑ Genital Herpes			

Have you ever had any serious illness not listed above? Yes No _____

Comments: _____

_____

_____

* Condition may require medication

COLLECTION COSTS: *Should it become necessary to place your account for Collections, and/or Small Claims Court, you shall pay all costs thereof including, but not limited to, attorney fees.*

CONSENT:

1. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
2. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
3. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deem fit to provide recommended treatment.
4. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1% finance charge maybe be added to my account, in addition to any collection charges.
5. I understand that where appropriate, credit bureau reports may be obtained.
6. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
7. I authorize the use of my social security number to file my dental claim.

Patient _____ Date _____

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Dental History

PATIENT NAME _____

What is the reason for your visit today? _____

Date of last Dental visit? _____ Last Dental Cleaning? _____ Last Full mouth X-Rays? _____

What was done at your last dental visit? _____

Name of previous Dentist _____

Address _____ City _____ State _____ Zip _____

Do you have dental problems now? _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do you use a: water-pick, toothpick, electric toothbrush, other? _____

Which of the following apply to you?

Are any of your teeth sensitive to:

- ❑ Hot or cold
- ❑ Sweets
- ❑ Biting or chewing
- ❑ Do you have mouth odors or bad taste
- ❑ Cold sores, blisters, other oral lesions

Do your gums bleed or hurt?

- ❑ Gum pain or bleeding
- ❑ Loose teeth or change in bite
- ❑ Food caught/stuck between teeth
- ❑ Parental history of gum disease
- ❑ Parental history of tooth loss
- ❑ Shredding Floss

Do you:

- ❑ Clench/grind teeth (while awake or asleep)
- ❑ Bite lips or cheeks regularly
- ❑ Hold foreign objects with you teeth (pencils, pipe, pins, nails, fingernails, etc)
- ❑ Mouth breathe while awake or asleep
- ❑ Have tired jaws, especially morning
- ❑ Smoke or chew tobacco
- ❑ Snore

Have you ever had:

- ❑ Orthodontic treatment
- ❑ Oral surgery
- ❑ Periodontal treatment
- ❑ Your teeth ground or the bite adjusted
- ❑ A bite plate or mouth guard
- ❑ Had a serious injury to the mouth or head

If so please describe, including cause:

_____

_____

Have you experienced:

- ❑ Clicking or popping of jaw
- ❑ Pain (joint, ear, side of face)
- ❑ Difficulty in opening or closing the mouth
- ❑ Difficulty in chewing on either side of the mouth
- ❑ Headaches, neck aches, or shoulder aches
- ❑ Sore muscles (neck, shoulders)

Would you like to keep all of your teeth all of your life? ○ Yes ○ No _____

Do you feel nervous about having dental treatment? If yes, explain. ○ Yes ○ No _____

Do you have any concerns about dental treatment? If yes, explain. ○ Yes ○ No _____

Have you ever had an upsetting dental experience? If yes, explain. ○ Yes ○ No _____

Do you use more than two pillows to sleep? ○ Yes ○ No _____

Have you lost or gained more than 10 lbs in the past year? _____

Have you been diagnosed with Osteoporosis/Osteopenia? _____

Do you take or have you taken Bisphosphonates? _____

Is there anything else about having dental treatment that you would like us to know? _____

_____

Who may we contact in case of emergency? Name _____

Relationship _____ Primary Phone _____ Secondary Phone _____

Comments : _____

_____