Name:_______________________________________

Address_____________________________________

City_________________**State**________**Zip**________

Parent's Cell Phone_______________________________________

Home Phone____

Date of Birth____

Social Security Number____________________________________
(necessary if you have dental insurance)

Emergency Contact Information

Name:____

Phone Number:____

Relationship To Patient:___________________________________

General Information

So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health. Please complete this medical history form. This information is, of course, confidential. If you are completing this for another person, what is your relationship to that person.

Father's Name:____

Mother's Name:____

Legal Guardian's Name:____

Medical History

Height:_____________________

Weight:_____________________

Physician's Name:____

Physician's Address:____

Physician's Phone Number:_______________________________________

Date of Last Physical Exam:______________________________________

How is your child's general health?

- ☐ None
- ☐ Aids/HIV
- ☐ Asthma
- ☐ Bleeding problems
- ☐ Diabetes
- ☐ Emotional disturbance
- ☐ Epilepsy
- ☐ Hearing problems
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ Kidney disease
- ☐ Learning disability
- ☐ Liver disease
- ☐ Lung disease
- ☐ Mental retardation
- ☐ Mononucleosis
- ☐ Other (please describe)
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Sickle cell anemia (disease)
- ☐ Sickle cell anemia (trait)
- ☐ Tuberculosis

History of other serious illness, hospitalization or accident?

- ☐ Yes
- ☐ No

Has your child ever had a blow to the head or to teeth?

- ☐ Yes
- ☐ No

Has your child ever had an x-ray or radiation therapy?

- ☐ Yes
- ☐ No

Does your child have any allergies?

☐ Yes
☐ No

If yes please list allergy____

Is your child receiving any medication at this time?

☐ Yes
☐ No

____

Medications:____

Allergies:____

Dental History

Previous Dentist:_______________________________________

Location:____

Do they have an adult help them floss?

☐ Yes
☐ No

What is the nature of today's visit?

☐ Regular Exam
☐ Emergency Exam
☐ Other ____

Are your teeth sensitive to any of the following?

☐ Hot____________
☐ Cold____________
☐ Pressure_________
☐ Sweets__________

Has your child complained of a toothache?

☐ Yes
☐ No

Are you nervous about dental treatment?

☐ Yes
☐ No

Have you ever had orthodontic treatment?

- [ ] Yes
- [ ] No

  If yes when____________________

  - [ ] Traditional Braces
  - [ ] Invisalign

Are you happy with your smile?

- [ ] Yes
- [ ] No

Does your child clench or grind their teeth?

- [ ] Yes
- [ ] No

Has your child ever been treated for gum disease?

- [ ] Yes
- [ ] No

COVID-19 Questions:

Do you/they have a fever or have a fever or you/they felt hot or feverish recently (14-21 days)?

- [ ] Yes
- [ ] No

Are you/they having shortness of breath or difficulties breathing?

- [ ] Yes
- [ ] No

Do you/they have a dry cough?

- [ ] Yes
- [ ] No

Do you have a runny nose?

- [ ] Yes
- [ ] No

Do you have a sore throat?

- [ ] Yes
- [ ] No

Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?

- [ ] Yes
- [ ] No

Have you/they experienced recent loss of taste or smell?

- [ ] Yes
- [ ] No

Have you/they come in contact with any confirmed COVID-19 positive patients?

- [ ] Yes
- [ ] No

Is your/their age over 60?

- [ ] Yes
- [ ] No

Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?

Yes
- [ ] No

Have you traveled in the past 14-days to any region affected by COVID-19?

- [ ] Yes
- [ ] No

Additional Information:

Does your child have any of the following habits?

- [ ] Bottles
- [ ] Pacifier
- [ ] Poor eating habits
- [ ] Thumb sucking
- [ ] Other (describe)____

Does your child receive fluoride in:

- [ ] Drinking Water at home
- [ ] Prescription
- [ ] None

Has your child had any unpleasant experiences?

- [ ] Yes
- [ ] No

____

Referred By:

- [ ] Doctor referred
- [ ] Another patient referred
- [ ] Insurance company website
- [ ] Google search engine
- [ ] other search engine

Media Waiver

I give my consent for photographs and or video taken of me to be used on the MIDM.io website, in brochures and flyers and news releases, and in presentations. I retain the right to have any photographs discontinued from use in any or all of the above venues upon request.

Financial Consent Form Rev. 1

We will be happy to file with your insurance company for you, however if your insurance has not paid within 90 days, the balance due becomes your responsibility. I agree and understand that if I do not pay the Practice the balance due and my account is placed in the hands of a collection agency and/or attorney for collection proceedings, I will be legally responsible for all costs of collection, including but not limited to: collection agency fees, court costs, litigation expenses, attorneys fees, as well as other incidental expenses incurred by the Practice. I agree to pay the Practice a cancelation fee, if I am not able to call 72 hours in advance (96 hours for Monday appointments). **It is our policy to charge a $100.00 for each missed appointment**. All patients are financially responsible for any email, phone, or extra research/correspondence beyond the scope of a regular dental visit. These services will be billed at a rate of $50.00 per 10 minute increments.
I understand that a 1 1/2 percent finance fee per month (18 percent annually) will be added to my account balance over 60 days regardless of pending insurance claims.
Should your account become delinquent, we will place the account with a collection agency, and you will be responsible for collection fees equaling 33% of any unpaid balance placed for collection, as well as interest at the rate of 10% per year. Additionally, if an attorney is engaged to pursue collection of the account, you will also be responsible for all reasonable attorney fees, court costs, sheriff or service of process fees and any other reasonable costs of collection.

Signatures__________________________**Date**_______________
Print Name________________________