Name:_____

Address_____

City_____**State**_____**Zip**_____

Cell Phone_____ **work** _____

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.

Your Name:_____

Relationship:_____

Medical History

Height:_____

Weight:_____

Physician's Name:_____

Physician's Address:_____

Physician's Phone Number:_____

Are you now under the care of a physician?

- [ ] Yes
- [ ] No

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

- [ ] None
- [ ] Alcohol addiction
- [ ] Anemia
- [ ] Anorexia
- [ ] Arthritis / Rheumatism
- [ ] Artificial (prosthetic) heart valve
- [ ] Artificial joint/ Prosthesis
- [ ] Autoimmune disease
- [ ] Blood disorders
- [ ] Bulimia
- [ ] Cancer
- [ ] Chemical dependency
- [ ] Chemotherapy
- [ ] Cortisone medication
- [ ] Damaged valves in transplanted heart
- [ ] Diabetes type I
- [ ] Diabetes type II
- [ ] Drug dependency
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Fainting spells
- [ ] Gastrointestinal disease
- [ ] GERD
- [ ] Glaucoma
- [ ] Hearing impaired
- [ ] Heart murmur
- [ ] Heart pacemaker
- [ ] Hemophilia
- [ ] Hepatitis other
- [ ] Hepatitis type A
- [ ] Hepatitis type B
- [ ] Hepatitis type C
- [ ] High/Low blood pressure
- [ ] HIV positive / AIDS / ARC
- [ ] Kidney problems
- [ ] Learning disability
- [ ] Leukemia
- [ ] Liver disease
- [ ] Lung disease / COPD
- [ ] Mental Health disorder
- [ ] Mitral valve prolapse

- [ ] Neurological disorder
- [ ] Organ transplant
- [ ] Osteoporosis
- [ ] Persistent swollen glands
- [ ] Previous infective endocarditis
- [ ] Prolonged bleeding
- [ ] Radiation therapy
- [ ] Removal of spleen
- [ ] Repaired CHD in last 6 months
- [ ] Respiratory ailments
- [ ] Rheumatic fever/ heart disease
- [ ] Shortness of breath
- [ ] Sickle Cell disease
- [ ] Sinus disorder
- [ ] Sleep disorder
- [ ] Stroke
- [ ] Thyroid problems
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Unrepaired, cyanotic CHD
- [ ] Venereal disease

History of other serious illness, hospitalization or accident?

- [ ] Yes
- [ ] No

_____

Do you have additional medical conditions or concerns?

- [ ] Yes
- [ ] No

_____

Do you drink alcoholic beverages?

- [ ] Yes
- [ ] No

Would you you consider yourself to be in fairly good health?

- [ ] Yes
- [ ] No

Have there been any changes in your general health lately?

☐ Yes
☐ No

_____

Medications:_____
_____
_____

Allergies:_____
_____

Smoking/ Vaping Status:

☐ Yes
☐ No

Women:

Are you pregnant or suspect that you may be?

☐ Yes
☐ No

Are you Nursing?

☐ Yes
☐ No

Dental History

Previous Dentist:_____

Location:_____

How long since your last dental visit?_____

What is the nature of today's visit?

☐ Regular Exam
☐ Emergency Exam
☐ Other _____

Are your teeth sensitive to any of the following?

☐ Hot_____
☐ Cold_____
☐ Sweets_____
☐ Pressure_____

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

How frequently do you brush your teeth?

- ☐ 3(+) a day
- ☐ Twice a day
- ☐ Once a day
- ☐ Weekly
- ☐ Seldom

Do your gums bleed when you brush your teeth?

- ☐ Yes
- ☐ No

Do you clench or grind your teeth?

- ☐ Yes
- ☐ No

Have you ever been treated for gum disease?

- ☐ Yes
- ☐ No

Are any of your teeth currently causing you pain?

- ☐ Yes
- ☐ No

Have you ever had any periodontal treatment?

- ☐ Yes
- ☐ No

How frequently do you floss your teeth?

- ☐ 1(+) a day
- ☐ 2-6 times a week
- ☐ 1-6 times per month
- ☐ Seldom
- ☐ Never

Are you concerned with loose teeth or teeth loosening?

- ☐ Yes
- ☐ No

Do you have any dental implants, dentures or partial?

- ☐ Yes
- ☐ No

Do you have any clicking or pain in your jaw?

- ☐ 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, headhache 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

How Did You Hear About Us?

_____

_____

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_____