PATIENT UPDATES

UPDATES

Has there been any change in your health since your last dental appointment? ___Yes ___No

For what conditions? ______________________________

Are you taking any new medications?______________ If so, what?______________________________

Patient's Signature______________________________ Date______________

Doctor's Signature______________________________ Date______________

PATIENT INFORMATION

Date ______________________________ SS/HIC/Patient ID # ______________________________

Patient Name ______________________________
Last Name First Name Middle Initial

Address ______________________________ Home (______) ______________ Cell (______) ______________

City ______________________________ Sex M F Age ______________

State ______________ Zip ______________ Birthdate ______________

Occupation ______________________________ ___ Married ___ Widowed ___ Single ___ Minor

Patient Employer/School ______________________________ ___ Separated ___ Divorced ___ Partnered for ______ years

Employer/School Address ______________________________

______________________________ Employer/School Phone (_____) ______________ Ext ______

INSURANCE

Who is responsible for this account? ______________ Relationship to Patient ______________

Insurance Co. ______________ Group # ______________

Is patient covered by additional insurance? __ Yes __ No Subscriber's Name ______________

Birthdate ______________ SS # ______________ Relationship to Patient ______________

Insurance Co. ______________ Group # ______________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________________ and assign directly to Dr. ______________ all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies), and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative Date

____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

ALLERGIES

___Aspirin
___Barbiturates (Sleeping pills)
___Codeine
___Iodine
___Latex
___Local Anesthetic
___Penicillin
___Sulfa
___Other ______________

____

HEALTH HISTORY

Any new serious illness __ Yes __ No If yes, please explain:

____

____

____

____

____

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

____

____

____

Pharmacy Name______________________________

Phone (______) ______________________________