Patient Information UPDATE

Name_____ Today's Date _____

Address _____ City, State, Zip _____

Cell Phone # _____Email _____

Employer _____ May we email or text you regarding your appointments **YES NO**

Do you currently use tobacco products **YES NO** If yes how often _____ Interested in quitting **YES NO**

Date of last visit to a physician _____ For what reason _____

SINCE YOUR LAST VISIT:

Have there been any changes to your health history? **YES NO** If yes, please list _____

Have you had any new DRUG ALLERGIES? **YES NO** if yes, please list _____

Please list current medications and purpose _____ _____

_____ _____

Have you been hospitalized? **YES NO** If yes, for what purpose? _____

In the last 5 years, have you had any surgeries or other major medical procedures (knee, hip), etc? **YES NO**

If yes, please explain _____ Do you require Premed antibiotics? **YES NO**

DENTAL Insurance Information

Insurance Company Name _____ Group #_____

I.D.# _____ Date Of Birth _____

Address _____ Phone # _____

City, State, Zip _____

Cardholder/Employee _____

Address _____ Phone # _____

City, State, Zip _____

SS # _____ Date of Birth _____

Relationship to Patient Self Spouse Parent Step-Parent

As a courtesy to our patients we file dental claim(s) to insurance plans that we do not contract with. If an insurance carrier denies the claim the patient assumes responsibility for the incurred charges or the balance on the account. Please give us updated insurance, address, and contact information at the time of check in. **A PAYMENT FOR ONE-THIRD OF THE COST OF DENTAL TREATMENT WILL BE REQUIRED AT THE TIME OF VISIT**. In an effort to decrease missed appointments we require a credit card on file if an appointment is missed or not rescheduled more than 24 hours prior to appointment time.

Patient Signature _____ Date _____