Patient Medical Health Update

Name ______________________________ Date ________________

Address ____

Home Phone (   ) __________________   Work (   ) _______________

Cell (   ) ____________________   E-mail ______________________________

Date of Birth _________________   School _____________________________

1. Are you currently under the care of a physician? YES NO

If yes, for what condition? ____

2. Has there been any change in your health since your last visit? YES NO

If yes, explain ____

3. Have you taken any medications within the last 12 hours? YES NO

4. List all medications you take on a regular basis ________________________

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5. List any medications you are allergic to ______________________________

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6. Have you had your blood pressure checked within the last 6 months?

YES NO

Was it normal? YES NO

7. Employer name and address ____

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8. Name and address of Insurance Company ________________________________

9. Please list any dental concerns you may have __________________________

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Late Charges

If I do not pay *the entire* new balance within 25 days of the monthly billing date, a late charge of 1% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except dental emergencies where there is prepayment for additional services. In case of default on payment, I agree to pay collections cost and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand my dental insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____ ________________

Signature (Parent or Guardian signature if patient is under 18) *Date*