

# Medical History Update

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Home \_\_\_\_\_ Work/Cell \_\_\_\_\_ Pager \_\_\_\_\_

Phone number to call if you leave \_\_\_\_\_

E-Mail \_\_\_\_\_

Has there been any change in the patient's health since last dental appointment?  Yes  No

If so, what? \_\_\_\_\_

Is the patient taking any kind of medication at this time?  Yes  No

If so, what? \_\_\_\_\_

Does the patient have an allergy (or adverse reaction) to any medication?  Yes  No

If so, what? \_\_\_\_\_

Does the patient have a latex allergy?  Yes  No

Would you, the parent, like to see the doctor today?  Yes  No

Do you have any questions regarding your child's appointment today?  Yes  No

If so, what? \_\_\_\_\_

Exam \_\_\_\_\_ Pro \_\_\_\_\_ F12 \_\_\_\_\_ BWX \_\_\_\_\_ PA \_\_\_\_\_ Pano \_\_\_\_\_ Dr. \_\_\_\_\_

I give my permission to complete the above noted treatment. I understand that I am responsible for any charges incurred for today's visit and any balance owed after the insurance has considered plan limitations, co-insurance, and deductibles.

**Parent's Signature** \_\_\_\_\_

## Have there been any changes in the following?

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone(s) \_\_\_\_\_

### Insurance Information:

Insured's Name \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Group Number \_\_\_\_\_

Phone Number \_\_\_\_\_

