Medical History Update

Patient's Name _____ Date _____

Home _____ Work/Cell _____

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

Has your child seen an orthodontist since their last visit?_____ Whom?_____

What are your expectations or concerns regarding your child's visit today?

_____

Home Address _____

City _____ State _____ Zip _____

Phone(s) _____

Insurance Information:

Insured's Name _____

Subcriber ID # _____ Date of Birth _____/_____/_____

Employer _____

Insurance Company Name _____

Group Number _____

Phone Number _____

Pediatric & Adolescent Dentistry
Debra C. Duffy, DDS, PA

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.

Print Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Office Use Only: Age: _____ Pending: S-_____Tx-_____ Pager#: _____

Weight: _____kg B/P: _____//_____ Photo: ❑Y___ ❑N ____