Medical History Update

Patient Name: _____ Birthdate: _____ SS#_____

Address: _____ City: _____

State: _____ Zip code: _____ Home Phone: _____

Cell Phone: _____ Email: _____

Employer: _____ Work Phone: _____

Employer's Address: _____

Dental Insurance? YES___ NO___ Insurance Company Name: _____

Policy Holder's Name: _____ S.S. /ID#: _____Relationship: _____

Pharmacy name/address: _____Phone: _____

Have you been a patient in the hospital the past 2 years?	YES	NO
Have you had surgery in the past 2 years?	YES	NO
Have you been under the care of a physician during the past 2 years?	YES	NO
Have you taken any kind of drug/ medication in the past year?	YES	NO

List: _____ Date: _____

Has anyone in your family been advised of difficulties during anesthesia?	YES	NO
Are you allergic to PENICILLIN or any other drugs or medication?	YES	NO

List: _____ Date: _____

Have you ever had excessive bleeding requiring special care?	YES	NO
Are you taking blood thinners such as aspirin? ...or Rx? _____	YES	NO

Circle any of the following you have had:

Heart trouble	Cough	Artificial joints	Psychiatric treatment
Heart murmur	Asthma	Congenital heart lesions	HIV/AIDS virus
Cancer treatment	Diabetes	High blood pressure	Cardiac pacemaker
Anemia	Arthritis	Rheumatic fever	Venereal disease
Epilepsy	Hepatitis	Sinus trouble	Tuberculosis
Stroke	MVP	Jaundice	COVID-19 date: _____

Other serious illnesses? _____ (Women) Pregnant? _____ Nursing? _____

CONSENT

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I understand that I may withdraw or revoke my authorization at any time. I may revoke this authorization by notifying my practice in writing.

I understand that by signing this Consent form, I am giving my consent to disclose and discuss my protected health information to carry out treatment, payment activities, and health care operations. The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

I have read, understand and agree to the above terms and conditions.

Print name Signature Relationship Date

PATIENT: _____

FINANCIAL AGREEMENT:

We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment. We are pleased to discuss our professional fees with you at any time. Your clear understanding of the Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility upon arrival at your first appointment.

ADULT PATIENTS Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

INSURANCE We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. If you are paid by the insurance company instead of our practice, you then become responsible for the total account balance and payment would be expected immediately. We ask that you sign this form and/or any other necessary documents that may be required by your insurance company.

DEDUCTIBLE/CO-PAYMENT We may ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.

DELINQUENT PAYMENTS It is our policy to charge a finance fee for outstanding patient balances. In addition, all payments returned due to non-sufficient funds will be subject to a fee.

MISSED/BROKEN APPOINTMENTS Unless cancelled 24 hours in advance, our policy is to charge a fee for missed appointments. Please help us service you better by keeping scheduled appointments.

REFUND POLICY You may discontinue treatment and request a refund at any time for any amount that you paid for treatment that you did not receive. Please contact your office if you would like to request a refund.

By signing, I confirm that I have read, understand, and agree to the above terms and conditions. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

PRINT NAME	SIGNATURE	RELATIONSHIP	DATE