Patient Update

Patient's Name: First: _____ Middle: _____ Last: _____

Preferred Name: _____ Date of Birth: _____ ☐ Male ☐ Female ☐ Other: _____

Address: _____
Street Address City State Zip

Please provide the best person to contact regarding appointments: _____
Name Relationship

Please provide the best cell phone number for confirmation texts: _____

Please provide the best email address for confirmation emails: _____

Physician: _____
Name of Physician City

Medical conditions: _____

Please indicate any changes in med history: _____

Please list any allergies: _____

Please list any medications that the patient is currently taking: _____
Medication 1 Medication 2

_____
Medication 3 Medication 4 Medication 5 Medication 6 Medication 7

Are there any concerns that you wish to address? _____

Is there anything causing discomfort at this time? _____

Is there anything else you would like us to know? _____

I hereby grant permission to the staff of this office for the administration of such anesthetics and the performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information as answered on this form is correct to the best of my knowledge.

I understand that I am financially responsible for the payment of any services rendered as well as broken appointment fees and all late payment service charges. Should I have dental insurance, I also understand that obtaining insurance coverage and benefit information as well as keeping up with the ever changing polices of my unique plan is my responsibility.

Patient or parent/guardian name: _____ Signature: _____

Relationship to patient: _____ Date: _____