the kids dentist

Medical History Update

Name: First: _____ Middle: _____ Last: _____

Nickname: _____ Date of Birth: _____ ☐ Male ☐ Female

Patient's Address: _____

Email Address: _____ Cell Phone: _____

Physician: _____

Please indicate any changes to your medical history: _____

_____

_____

Please list any allergies: _____

_____

Please list any medications you are currently taking: _____

_____

What is the reason for today's visit? _____

Are you having any discomfort at this time? _____

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 name: _____ Date _____

Signature: _____ Date: _____