Returning Patient
Medical History Update

Date: _____

Patient's Name: _____ DOB: _____

Parent's Names: _____

Address, City & Zip: _____

Primary Phone: _____ Other _____

Email:_____

Dental Insurance Co: _____

Please initial if you would like to receive TEXT appointment reminders _____

To assist us in keeping your child's medical history up to date, please answer below:

1. Has your child's **medical history** changed since your last visit? Y or N

   If so, how? _____

2. Is your child currently taking any **medication** (vitamins/supplements)? Y or N

   If so, what? _____

3. Any **behavioral changes/diagnosis** that may affect our care? Y or N

   _____

4. Has your child had any recent injury to the head/mouth/teeth? Y or N

   If so, please describe _____

5. Do you have any concerns for your child for today's appointment? Y or N

   If so, please describe _____

OFFICE POLICIES

We reserve your appointment time specifically for you. If you need to reschedule, we request at least 24 hr notice. A fee, up to $50, may be assessed for late cancellations and/or missed appointments. As a courtesy we will file your dental insurance claims for you. Please notify our office when any change in your insurance coverage occurs. We will provide insurance estimates to you, however it is not a guarantee that your insurance will pay exactly as estimated. All charges you incur are your responsibility. We allow 60 days for your insurance company to pay your claim. Unpaid balances are your responsibility. Accounts more than 30 days past due are subject to finance charges of 1.5% monthly.

Signature: _____

Print Name: _____ Relationship:_____

We would like to provide the best possible care for your children & are always striving to improve our services.

Please offer your comments below:

1. What do you like most about your treatment in our office?

   _____

2. What would you suggest to improve our service in the future?

   _____