ADULT INFORMATION UPDATE

NAME: ____

Cell Phone: ______________________________ Home Phone: ______________________________

Email: ____

1. HAS THERE BEEN A CHANGE IN YOUR ADDRESS, PHONE OR OTHER PERSONAL INFORMATION? YES NO

Home Address____

Your Employer ____

Work Phone ______________________

Work Address____

Name of Spouse______________________________________ Birthdate _____________________

2. ARE YOU RECEIVING MEDICAL TREATMENT OR CURRENTLY TAKING MEDICATION? YES NO

Your Physician____ MD Phone ____________________

Date of Last Exam _________________

Reason for Exam ____

Please list all medications currently being taken: ____

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3. HAVE YOU BEEN HOSPITALIZED RECENTLY? YES NO

Dates of Hospitalization ____

Reason for Hospital Admittance ____

4. WOULD YOU LIKE US TO CREATE AN INSURANCE CLAIM FOR YOU? YES NO

Ins. Co. Name ____

Address ____

Ins. Phone # ______________________ Group # _________________Plan #______________________

Employer ______________________________________

Subscriber Name ____ Birthdate __________________

Subscriber SSN ________________________________ Relationship to Patient ___________________

<u>INSURANCE RELEASE & FINANCIAL RESPONSIBILITY</u>

I hereby authorize the release of any information, including but not limited to the records of any examinations, treatment and diagnosis to my insurance company or companies. This release is for the purpose of facilitating payment of my insurance benefits directly to our office for dental treatment.

Our office will assist with insurance billing, however treatment is not rendered on the assumption that charges will be paid by insurance. All dental treatment fees are the direct responsibility of the patient. There will be a 1% service charge (12% annually) added to any unpaid balance over 30 days. Collection referral and clerical service fees are added to any unpaid balance after 60 days. Our NSF check and services fees are each $45.00.

I understand I am responsible for an accurate medical history and that all medical information is important in arriving at a diagnosis and treatment plan. I understand it is imperative to report any changes in my health or medication to the dentist.

SIGNATURE OF PATIENT ____ DATE _______________