Medical History Update

Patient Name:___________________________________ Date of Birth:____________________
Last First MI
Age: ____________ SS# _________________________ DL# ______________________________
Physical Address:_____________________ City:________________ St:____ Zip:___________
Billing Address:_______________________ City:_______________ St:_____ Zip:___________
Home Phone: _______________________ Work Phone: _______________________
Cell phone:_________________________ Email Address:________________________
Emergency Contact Name : ______________________ Phone:___________________________
Relationship of emergency Contact to Patient : ____

Has your Dental Insurance changed? _______________ **(if yes, please fill in below)**

Insurance Company Name: _________________________ Phone : _______________________
Subscriber Name:_____________________ Date of Birth:_____________ SS#:_____________
ID#:____________________ Group #:_________________ Employer:______________________

Name of Primary Care Physician:_______________________ Phone:______________________
Specialty Care Physicians
Name: ____________________ Specialty_________________ Phone _______________________
Name:____________________Specialty__________________Phone_________________________
When's the last time you were under Physician care? ________________________
Have you had Any Surgeries and/or Hospitalizations since your last visit? If so please list dates and reason(s) ____
Please list all current Medication and reason for medication:
____
____
List any known allergies :
____

Please list any changes in medical history since last visit_______________________________
____

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Preferred Pharmacy Name and location: ____
Pharmacy Phone Number: ____
Do you have any area causing any discomfort? ______________________________________
Any concerns you'd like the Doctor to address specifically today? :_______________________
____

How Many times daily do you Brush? :_______ Floss? :_______ Drink Coffee/Tea? :________
Do you snore?:_________________ If so, do you use a CPAP? ______________________

48 business hours is required to cancel any appointments in our office, if canceled 24 hours of the scheduled appointment a $50.00 fee is assessed to your account. If the appointment is canceled the day of your appointment a $100.00 fee is assessed to your account, unless it is an emergency.

Balance is due at the time service is rendered unless previous payment arrangements have been made. Our office is happy to file with your Insurance as a courtesy, and we strive to assist you in maximizing the most of your benefits available to you. Should for any reason Insurance not submit payment or a procedure is denied, it is ultimately the patient's responsibility. Insurance companies are not always accurate and do not guarantee payment or availability of benefits when we receive a breakdown of your benefits. This breakdown is where we obtain the information to provide you with a pre treatment estimate. Any remaining balance or denial from Insurance is between the patient and your Insurance Company.

____ ____________________

Patient or guardian Signature Date

Medical History Update

Communication Preferences

Patient Name ___________________________________ Date of Birth ____________________

Town Square Dental may communicate with me through the following methods:

☐ Automated Appointment Reminder System via Text. Cell Number _________________________

☐ Phone Call and Voice Message. Phone Number(s)_______________________________________

☐ Phone Call and No Voice Message. Phone Number(s) ____________________________________

☐ Email Address____

☐ Other ____

☐ I do not wish to receive any contact from Town Square Dental via phone call, voicemail, text, or email. I understand that if I miss a scheduled appointment, I will be charged a Broken appointment fee of $50.00

How may we contact you? ____

I hereby give consent to Town Square Dental to disclose Protected Health Information (PHI) to the following individuals:

Name: __________________________________ Relationship: ___________________________

Name:___________________________________ Relationship: ___________________________

Name: __________________________________ Relationship: ____________________________

☐ I understand that I have the right to revoke this consent, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

☐ I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this consent.

Patient/Guardian Signature _____________________________________ Date _______________