

Medical History Update

Patient Name: _____ Date of Birth: _____

Last	First	MI
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Age: _____ SS# _____ DL# _____

Physical Address: _____ City: _____ St: _____ Zip: _____

Billing Address: _____ City: _____ St: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell phone: _____ Email Address: _____

Emergency Contact: _____ Phone: _____ Relation: _____

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? : _____ Does flossing cause pain? _____

Drink Coffee/Tea? : _____ If so, how many times a day? _____ Week? _____

Do you smoke/use tobacco products? _____ Do you use Nicorette gum? _____

Do you snore?: _____ If so, do you use a CPAP? _____ How long? _____

48 business hours is required to cancel any appointments in our office. A \$50 cancellation fee will be assessed to your account. If your appointment is canceled the day of, there will be a \$100 cancellation fee assessed. These fees are not a refundable fee.

If you are scheduling treatment there is a deposit required of half (1/2) of your patient portion due prior to scheduling.

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 _____