

HEALTH HISTORY UPDATE

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____
Street Apartment #

City State Zip Code

Email Address: _____

Emergency Contact: _____ Relationship to You _____ Phone Number (s) _____

Your Employment Information

Employer Name: _____ Occupation: _____

Address: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

• **Have you noticed any change in your general health?** _____

• Are you now under the care of a physician? Yes No

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

Please describe any current medical treatment, impending surgery, completed surgery, or other treatment:

Prescribed/OTC medications/supplements you are currently taking: _____

Medication Allergies: _____

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will assist in completing the necessary insurance forms. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I grant permission for said dental office to send any necessary information to the insurance company to process my dental claim such as dental x-rays, narratives, medical history and chart notes.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian Date: _____

Dr. Tana M. Busch / Dr. Tom Hutchison / Dr. Jason Carlyon Date: _____