PATIENT UPDATE

Office Use Only
Reviewed by: _____
Doctor: _____

PATIENT'S NAME: _____

X-rays may be taken as part of today's dental examination. I UNDERSTAND that the doctor's recommendation for x-rays is based on my child's individual needs and NOT on what the insurance company determines they will cover. I assume financial responsibility for the cost of x-rays should my insurance company deny payment. ***INITIALS:_____*

If there is any reason why your child should not have x-rays taken today, please notify us*

MEDICAL UPDATE:

1. Has there been any change in your child's health since your last visit? ☐**YES** ☐**NO**
   If so, please explain._____
2. Is your child currently under the care of a physician and/or taking any medication(s)? ☐**YES** ☐**NO**
   If so, please explain/list all medications: _____
   _____
3. Has there been any injury to your child's teeth, head, or neck since his/her last visit? ☐**YES** ☐**NO**
   If so, please explain._____
4. Are there any questions or concerns you wish to bring to the doctor's attention at this visit? ☐**YES** ☐**NO**
   If so, please explain._____
5. Has your child been seen by an orthodontist and if so, have recent x-rays been taken? ☐**YES** ☐**NO**
   Orthodontist's name and city: _____

FAMILY RECORD UPDATE:

Pediatric Dental Specialists may use my cell phone number to call or text regarding appointments, treatment, insurance, and my account. I understand that I can withdraw my consent upon written request.

☐ I consent to this statement Initials _____

☐ I do not consent to this statement Initials _____

☐ **My cell phone number, E-mail, address and home phone numbers on file are all current and do not need to be updated.**

Updated Cell: _____ **Updated Email:** _____

Updated Mailing Address:_____

INSURANCE INFORMATION:

☐ **- There have been NO CHANGES to my insurance since our last visit here**

☐ **- I have NEW INSURANCE:**

Subscriber's Name:_____ Insurance Company Name:_____

Date of Birth: _____ /_____ /_____ Insurance Phone #:_____ __

Social Security or ID #:_____ Group #:_____

Employer:_____ ☐ - ***check here if this is dual insurance coverage***

FINANCIAL AGREEMENT:

All accounts are due and payable at the time services are rendered, unless prior arrangements have been made. The total fee is your personal obligation. However, if you have dental insurance which will cover the services rendered, please be sure you have informed our office. As a courtesy, we will file the necessary insurance claim for payment on your behalf.

We will help expedite your claim so that you receive the correct amount to which you are entitled under the terms of your policy. The difference (if any) between amounts paid by your insurance (where there is an assignment of benefits) and the amount billed is your responsibility.

I have read the above and I understand that I am responsible for all charges incurred.

By signing below, I certify that I have completely read, understand as well as agree to the above statement(s) herein:

_____ _____
Signature Date

_____ _____
Print Name Relationship to Child