Affordable Dental care
A good smile starts with healthy teeth.

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frontdesk@theaffordabledental.com

AFFORDABLE DENTAL PATIENT UPDATE FORM

PATIENT DETAILS

Name : _____ (Last Name) _____ (First Name) _____ (Middle Name) _____ (Title)

Preferred Name : _____ ○ Male ○ Female

Address : _____ City : _____ State : _____ Zip : _____

SSN : _____ Date of Birth : _____

Home Phone : _____ Work Phone : _____

Cell Phone : _____ Email Address : _____

Employer : _____ Occupation : _____

Marital Status : ○ Domestic Partner ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

NOTE: We will contact you by Email and/or by Phone for appointment confirmation.

Medical History Update

Has there been any change in your health since your last appointment? ○ Yes ○ No

If Yes, Explain _____

Are you taking any medications at this time? ○ Yes ○ No

If Yes, Please list each one _____

Do you have any allergies to medications? ○ Yes ○ No

If Yes, Please list them _____

Have you been hospitalized within the past few years? ○ Yes ○ No

If Yes, Explain _____

Women: Are you pregnant? ○ Yes ○ No Due Date : _____

INSURANCE - Secondary

Patient's Relationship to Subscriber: ○ Self ○ Spouse ○ Child

Subscriber Name : _____ Subscriber DOB: _____

Subscriber SSN / ID : _____ Subscriber Employer : _____

Insurance Co. Name : _____

Insurance Co. Address : _____

Insurance Co. Phone : _____ Group Number: _____ Group Name: _____

ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Affordable Dental Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Dentist to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature : _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Relationship : _____ Date : _____

Patient/Guardian Signature: _____ Date: _____

Doctor Signature: _____ Date: _____