

Patient Information Updates

Patient Name: _____ **Date of Birth:** _____

Has any of the following contact information changed since your last visit? Yes No

If Yes, please complete and update all of the following information:

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Email Address: _____

Mom/Legal Guardian Work Phone: _____ Mom/Legal Guardian Cell Phone: _____

Dad's Work Phone: _____ Dad's Cell Phone: _____

Are there any dental insurance changes that we have not been made aware of? Yes No

If yes: Group Name: _____ ID#: _____ Phone # _____

Policy holder: Name: _____ Birthdate: _____ SSN#: xxx-xx-xxxx

**** For Staff Use Only**** The most current dental insurance card has been presented for verification to: _____

Are there any updates in the medical history? (allergies, surgeries, medications, etc.) Yes No

If yes, Explain: _____

**** For Staff Use Only**** If there are significant changes, please provide patient with a New Patient Form

CONSENT FOR DENTAL TREATMENT

I request and authorize First Care Dental of Palm Beach PA and its staff to perform cleanings, exams and place topical fluoride treatments on my child. I request and authorize dental x-rays to be taken on my child as considered necessary by First Care Dental of Palm Beach PA and its staff to diagnose and/or treat my child's dental needs. I acknowledge that I have been explained all the behavior management techniques that may be used with my child while experiencing dental treatment. I have been given the opportunity to discuss any questions that I may have.

Parent/Guardian Signature _____ **Date** _____

Parent/Guardian Printed Name _____

Relationship to Patient _____