

ANNUAL INFORMATION UPDATE

PATIENT NAME:		
ADDRESS:		
CITY:	STATE:	ZIP:
BIRTHDATE:	AGE:	
SCHOOL:	GRADE:	
HOME PHONE:	WORK PHONE:	
OTHER(cell/pager):	EMAIL(parent):	
PARENT(S) / GUARDIAN(S):		RELATIONSHIP:
EMERGENCY CONTACT (RELATIONSHIP):		
EMERGENCY CONTACT PHONE:		

Has the patient’s medical history changed since their last visit to this office? Y__ N__
 If so, how? _____

Is the patient being seen by a physician for a particular problem, or anything you feel we should be aware of? If yes, what? Y__ N__

Is the patient taking any medications at this time? If yes, what? Y__ N__

Are there any special concerns regarding the patient’s dental health that we can address today? Y__ N__

PRIMARY SUBSCRIBER:	BIRTHDATE:
PRIMARY INSURANCE:	GROUP #:
SUBSCRIBER ID #:	EMPLOYER:
SECONDARY SUBSCRIBER:	BIRTHDATE:
SECONDARY INSURANCE:	GROUP #:
SUBSCRIBER ID #:	EMPLOYER:

INSURANCE AUTHORIZATION / ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits for any services furnished me, or my dependants, be made on my behalf to: Eastside Pediatric Dental Group, PLLC.
 I authorize any holder of medical information about me, and/or my dependants, to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that I am responsible for any and all charges not paid by my insurance plan(s).

X _____ DATE _____