Dr. Maggie Davis & Associates
PEDIATRIC DENTISTS

Returning Patient
Medical History Update

Date:_____

Patient's Name:_____ DOB:_____

Address, City & Zip:_____

MOTHER'S INFORMATION Same as address above ☐

Name: _____

Address, City & Zip: _____

Mom Cell #:_____ Mom Work #:_____

FATHER'S INFORMATION Same as address above ☐

Name: _____

Address, City & Zip:_____

Dad Cell #: _____ Dad Work #:_____

If patient is 18 or older Cell #:_____

Preferred Phone # for confirming appointments: _____

Preferred E-mail for account:_____

Dental Insurance Co: _____

Patient's School: _____

To assist us in keeping your child's medical history up to date, please answer the following questions.

If no changes, please check here ☐ & sign below:

1. Has your child's medical history changed since your last visit? Y or N

   If so, how?_____

2. Is your child currently taking any medication (including fluoride)? Y or N

   If so, what?_____

OFFICE POLICIES

- A fee, up to $75, may be assessed for late cancellations and/or missed appointments. **A 48 hour notice is required.**
- Please notify our office with any insurance changes and an insurance estimate will be provided for needed treatment. Although we allow 30 days for insurance to pay your claim, all charges incurred are **your** responsibility.
- Accounts 30+ days past due are subject to finance charges of 1.5%

Signature:_____

Print Name:_____Relationship:_____

Future Periodic Updates:

Date:_____ Best Phone #:_____
Changes in patient's health:_____
_____
_____
Parent Signature:_____
Reviewed by (Staff Initials):_____

Date:_____ Best Phone #:_____
Changes in patient's health:_____
_____
_____
Parent Signature:_____
Reviewed by (Staff Initials):_____