PLEASE LIST ALL MEDICATIONS YOU ARE TAKING AND REASONS: (INCLUDING ASPRIN)

Print Form

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MEDICAL HISTORY, DENTAL SERVICES AND INSURANCE AUTHORIZATION

The above Medial History is correct, and I will advise your office of any future changes. I authorize release of any information relating to treatment.
I understand I am responsible for all changes to my account. As a courtesy to our patients, in certain cases, we will process your insurance claims, however, in order to control our billing cost and reduce fee increases, we request your account balance be paid at the time of service.

SIGNED: DATE:

(Parent/Guardian if patient is under age 18)

NOTES: