Commonwealth Pediatric Dental

Raymond Murphy Jr., DMD

Medical/Dental History Update

(For the safety of our patients, we require a medical history update every six months)

Patient's Name: _____ Patient's DOB: _____

Have there been any changes to your dental insurance plan? Yes \ No

Any changes to your name, address, or contact information? Yes \ No

Please list changes: _____

Personal E-mail:_____ Mobile phone #:_____

Have there been any changes to your medical history? Yes \ No

Please list all changes: _____

Have there been any changes to your dental history? Yes \ No

Please list all changes: _____

Do you have any new allergies? Yes \ No

If yes, please list: _____

Are you taking any new medications? Yes \ No

If yes, please list:_____

Do you have any questions or concerns about your child's dental health that we can answer today? Yes \ No

If yes, please list _____

INFORMED CONSENT FOR PARENTS/GUARDIANS ACCOMPANYING THE CHILD

I hereby authorize the dentists and staff at Commonwealth Pediatric Dental to perform diagnostic aids including an examination, x-rays, photographs, cleaning and fluoride treatment, when necessary, as the standard of care to properly diagnose and record all dental conditions. (Please cross out any treatment that you do not want performed.) I authorize my insurance company to pay Commonwealth Pediatric Dental all insurance benefits otherwise payable to me for services rendered. I also authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges for services rendered whether it is covered by my insurance, all broken appointment fees and all late payment service charges. I also understand that obtaining insurance coverage and benefit information is my responsibility and not the responsibility of Commonwealth Pediatric Dental. This consent is to remain in effect from the date indicated until cancelled in writing.

Signature: _____

Relationship to patient: _____ Date: _____

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