Killeen Family Dentistry

Today's Date:_____

6-Month Check-Up Update Form

Patient Name:_____ Date of Birth:_____ Age:_____

Patient Ethnicity:_____ Primary Language:_____

Parent/Guardian Name:_____

Current Mailing Address:
_____
_____
_____

Home Phone:_____
Cell Phone:_____

Email Address:_____

Have there been any changes to your dental insurance since your last visit? Yes No
If yes, what is your new dental insurance?_____

Are you currently seeing a physician? Yes No
If yes, what is the condition being treated? _____

Do you have any new/existing medical conditions? Yes No
If yes, please describe:_____
_____

Are you currently taking any medication? Yes No
If yes, what medication are you taking and what for? _____
_____

Are you allergic to anything? Yes No
If yes, please list your allergies:_____
_____

Are you currently pregnant? Yes, _____ months No N/A

Informed Consent:

1. I authorize the doctor/staff to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my/the patient's dental needs.
2. I authorize the doctor to perform all recommended treatment mutually agreed upon by me and the doctor/staff, and to use the appropriate medication and therapy indicated for such treatment.
3. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor can choose and employ such assistance as deemed fit to provide recommended treatment.
4. I have answered all the above questions to the best of my knowledge. If there have been any changes to my insurance, health or medication, I have and/or will inform my dentist during my next appointment.

I, the undersigned, hereby authorizes that I have read, understand and agree to the above conditions.

_____ _____
Signature of Patient / Parent / Guardian Date

----------FOR OFFICE USE ONLY----------

MEDICAL HISTORY UPDATED

Weight_____ Dr_____ Date_____