CORONADO PEDIATRIC DENTISTRY

PATIENT INFORMATION UPDATE

Date: ____________________

Patient(s) Name(s)______________________________Date(s) of Birth ________________

Address____________________________________ City/State___________ Zip_______

Parent / Guardian Information

Name________________________ Name________________________

Relationship_________________ Relationship_________________

Home Phone _________________ Home Phone _________________

Work Phone _________________ Work Phone _________________

Cell Phone _________________ Cell Phone _________________

E-Mail _____________________ E-Mail _____________________

Medical Health Information (since last visit)

Have there been any health changes? (including medications, etc.)

Has your child had any injuries to the teeth, head, or neck?

Are there any special concerns you wish to bring to the doctors attention today?

Insurance Information

Has your insurance changed since the last visit? Yes No

(If yes, please provide check-in coordinator with your current information)

We ask for 24 business hours notice for any cancellation of your scheduled appointment. If notice of cancellation is not given there may be a charge of $50 (per appointment cancelled) to your account for the time scheduled. If it is an Oral Sedation/General Anesthesia appointment, we ask for 48 business hours notice to avoid loss of your deposit.

Signature of Responsible Party ______________________________