2020 YEARLY MEDICAL HISTORY UPDATE

Name: _____

Do you prefer? EMAIL/TEXT or PHONE CALL * FOR CONFIRMING YOUR APPOINTMENTS**

**** EMAIL ADDRESS: _____**

CELL # _____ Home # _____ Work # _____

Home Address:_____
Street / Apt # City Zip

Any CHANGES in your DENTAL INSURANCE? NO / YES * Please provide front desk with new information**

Any CHANGES in your MEDICAL HISTORY? NO / YES _____

_____

Are you currently TAKING any PILLS or PRESCRIPTIONS? NO / YES * PLEASE LIST ALL NEW & OLD**

_____

_____

Do you require PREMEDICATION before dental treatment? NO / YES ***PLEASE LIST _____

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits.

_____ _____/_____/_____
Patient, Parent / Legal Guardian or Responsible Party DATE

Dr. Keith Schwartz

Family and Cosmetic Dentistry

OFFICE POLICY

Listed below are our office policies for all of your scheduled appointments. We would appreciate a 24 hour notice if you cannot make your appointment. Please know that we value your time. Our office reserves each appointment just for you. A cancellation the same day affects many people.

DEPOSIT FOR APPOINTMENT POLICY

Any appointment scheduled for an hour and a half or more requires a 20% deposit to reserve the appointment.

NO CALL/NO SHOW POLICY

- The first time this happens you will be given a warning.
- The second offense you will be charged $50/hour.
- The third time you no call/no show you will be sent a certified letter from the practice explaining that you are being discharged from our practice.

Thank you for your cooperation.

Patient Name (print)_____ Date_____

Patient Signature_____