Montgomery Dentistry
Annual Update Form

Patient Name: _____ (_____) __ Date: _____
Last First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ Drivers License #: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____

Address: _____
Street City State Zip Code

E-mail address: _____ Employer: _____
Primary Insurance Carrier: _____ ID# _____ Name/DOB: _____
Secondary Insurance Carrier: _____ ID# _____ Name/DOB: _____

Emergency Contact

Name _____ Phone # _____
Nearest relative not living with you

Medical History

Medical Doctor's Name _____ Address _____ Phone # _____
Are you under a doctor's care now? YES NO Why? _____
Are you allergic to any medications or substance? YES/NO What? _____
Have you ever been told you need to Pre-medicate prior to dental treatment? _____ YES NO
Do you take any blood thinners? _____ YES NO
Women Only: Are you pregnant? YES, month? _____ NO Nursing? YES NO Taking birth control pills? YES/NO

Have you ever had any of the following? Please circle those that apply:

AIDS/HIV Pos.	Allergies	Anemia	Artificial Joints	Asthma	Blood Disease
Cancer	Cold Sores	Cosmetic Surgery	Diabetes	Dizziness	Epilepsy
Excessive Bleeding	Fainting	Glaucoma	Growths	Hay Fever	Head Injuries
Heart Disease	Heart Murmur	Hepatitis _____	High Blood Pressure	Jaundice	Kidney Disease
Liver Disease	Mitral Valve Prolapsed		Nervous Disorder	Pacemaker	Ulcers
Psychiatric Care	Radiation Treatment		Respiratory Problems	Rheumatic Fever	
Rheumatism	Sinus Problems		Special Needs Pt.	Stomach Problems	
Stroke	Tuberculosis	Tumors	Venereal Disease	Walker/Cane	Wheelchair

Have you had any recent surgery? _____
Have you had any serious illness not marked above? _____

FINANCIAL RESPONSIBILITY AND CONSENT FOR SERVICES

The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor chooses and employ such assistance as deemed fit to provide recommended treatment.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Due to changes and the standardization of The Health Insurance Portability and Accountability Act (HIPAA) you will see a more precise listing of procedures and fees.

I, the undersigned certify that I (or my dependent) have insurance coverage with the above listed insurance company and assign directly to Montgomery Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment. I authorize the use of this signature on all insurance submissions. Any appointment needing to be rescheduled that does not receive 48 hours notice will be subject to a $50.00 charge. This charge is above and beyond any estimate for treatment. I authorize the release of past medical/dental payment history and/or a credit report. . If the amount owed is more than what is estimated per the Payment Plan Authorization Form, the Patient (Parent or Guardian if minor) agrees to the continuation of payments as agreed by said form until the balance is paid in full. In the event that payments are not received by the agreed upon dates, I understand that a finance charge of 1.5% each month there is a balance may be added to my account. Statements are sent once a month and payable within 10 days of receipt of statement. The undersigned accepts the fees charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state. I authorize the merchant to convert my check to Electronic Funds Transfer (EFT) or paper draft, and to debit my account for the amount of the transaction. In the event that my draft or EFT is returned unpaid, I agree that a fee as allowed by law may be charged to my account via draft or EFT. I grant my permission to you or your assignee, to telephone me at home or at my work (including cell phone numbers) to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Signature: _____ Date: _____
Patient, parent or guardian/responsible party

FOR OFFICE USE ONLY

B/P _____**, Pulse** _____ **TAKEN BY** _____**, DATE** _____
B/P _____**, Pulse** _____ **TAKEN BY** _____**, DATE** _____

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Entered in computer by: _____ **Doctor Signature:** _____