



Patient History Update

Patients Name _____ D.O.B. _____

Is there any change in medical history? YES _____ NO _____
If so what?

Any Changes in medications? YES _____ NO _____
Has your insurance changed? YES _____ NO _____

If yes, what is your new/updated insurance _____
Please inform front office with all new updated insurance information.

Mailing Address: _____
_____ Cell # _____ Relationship _____
_____ Work# _____ Relationship _____
_____ Emerg# _____ Relationship _____

Email address: _____

Responsible Party Name: _____ Relationship: _____

Other than Responsible Party, who else can bring to appointment, discuss financials or schedule appointments?

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

To the best of my knowledge, the questions on this update have been accurately answered. I understand that providing incorrect information can be dangerous to my health and that it is my responsibility to inform Family Orthodontics of any changes in my medical status. I also authorize Family Orthodontics to perform any necessary orthodontic services that I may need.

Signature: _____ Date: _____

For Staff Use Only

Location _____ **Chart#** _____ **Updated on:** _____

Entered into Orthotrac by _____ **(initials only)**