Welcome Back to Ascent Dental Group

We try our best to keep your record current, please assist us in keeping your record current.

Patients Name:_____________________________ DOB:_________________________

Guardians Name:___________________________

Change of address? YES______NO______
If yes please update:____

Please update the following phone numbers
Home #____________________________
Cell #_______________________________
Work #_____________________________
Emergency #________________________ Person to Contact:__________________

Please update email address:______________________________@_______________________

Have you had any changes to your Dental Insurance? Yes____ No____
If yes, please explain:____

Have you had any changes to your medical history since your last visit? Yes_____ No_____
If yes please explain:____

Are you taking any medications? Yes_____ No____
If yes please explain:____

Do you use Tobacco? Yes___ No_____ Controlled Substances? Yes____ No_____

Do you have any allergic reactions? Yes____ No___ If yes, explain_______________________________

Do you need to be PRE-MEDICATED before dental procedures due to medical conditions? Yes____ No_____
If yes, please describe:____

Woman only: Are you pregnant? Yes__ No__ Nursing? Yes__ No__ Taking contraceptives? Yes__ No__

AUTHORIZATION AND RELEASE
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me and or my child during the period of such Dental care to third party payers and/or health care practitioners. I authorize and request my insurance to pay directly to the dentist or dental group. I understand that my dental insurance carrier may pay less the actual services rendered on my behalf or my dependents. I understand I would be responsible for the balance if my carrier pays less than the actual service rendered.

Signature of patient (parent or guardian if minor)__________________________________ Date:______________