Wilmington
Dental Studio
Dr. Abrahamian & Dr. Orchanian

Medical Update

PATIENT INFORMATION

First Name		Last Name			
Birth Date		E-mail			
Cell Phone		Work Phone		Home Phone	
Address		City		State	ZIP Code

INSURANCE INFORMATION

Has there been any change in dental insurance since your last visit? ❑ Yes ❑ No

We submit to your insurance as a courtesy to you. In the event your insurance pays less than the estimated amount, you are responsible for the unpaid balance. All balances over 90 days will be subject to 1.5% (18%) monthly finance charge.

PRIMARY DENTAL INSURANCE COMPANY

Primary Policy Holder	First	Last			
Relation		Gender ❑ Male ❑ Female	Birth Date	S.S. #	
Insurance Co. Name		Telephone			
Address		City		State	ZIP Code
Group #		Member ID#			

HEALTH HISTORY

Are you under the care of a physician? If yes, please complete the line below. ❑ Yes ❑ No

Date of Last Visit		Physician Name		Physician Phone	

Any hospitalization, surgeries or serious illnesses in the past? ❑ Yes ❑ No

Please explain

Any history of head & neck radiation? ❑ Yes ❑ No

FOR WOMEN ONLY

Are you pregnant? ❑ Yes ❑ No If yes, number of weeks

ALLERGIES

Please list any allergies/ allergic reactions.

MEDICATIONS

Please list any medications you are currently taking below.

FORM COMPLETION

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:		Date:	

IF PATIENT IS A MINOR

Form signed by:		Relationship to Patient:	