RETURNING PATIENT FORM

Patient Name (First and Last Name): ____ Date: ________________________

Phone: _________________________ 2nd Phone: ___________________________Email: ________________________________

Any changes to home address? If yes, please list new address below:

____

Do you have a new dental insurance? If yes, please list Name and ID # below:

____

Are you having dental pain today? ◯ YES ◯ NO

Please check any dental concerns:

◯ Cavities ◯ Color of Teeth ◯ Grinding of Teeth ◯ Gum Infections
◯ Jaw Sounds ◯ Mouth Breathing ◯ Orthodontics ◯ Sensitive Teeth
◯ Toothache ◯ Trauma ◯ None
◯ Other: ____

Have there any been changes in your child's medical history? ◯ Yes ◯ No
If yes: ____

Is your child currently taking any medications? ◯ Yes ◯ No
If yes, please list: ____

Any hospitalization or surgery since your child's last visit? ◯ Yes ◯ No

Is your child allergic to any food or medication? ◯ Yes ◯ No
If yes, please list: ____

APPOINTMENT CANCELLATION AND NO-SHOW POLICY

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, we require at least a 24-hour advanced notice. This courtesy makes it possible to give your reserved room to another patient who would like it. **Repeated cancellations with a maximum of three missed appointments without notice will result in loss of future appointment privileges.** We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. We, of course, would appreciate the same courtesy from you. If you have any questions or issues that are preventing you from keeping your appointments, please call us ahead of time at (209) 400-2018 and we will gladly reschedule your appointment to a more convenient time. I understand and agree to Bethel Kids Dental's policy about treatment appointment and cancellation.

I certify that I have read and understand the contents of this form. I will not hold Bethel Kids Dental, doctors, and staff, responsible for any action they take or do not take because of errors or omissions that I have made in completing this form. I will notify Bethel Kids Dental any changes on my child's information, and health.

Print: ____ Signature:_____________________________ Date: _________________

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