RECALL HEALTH HISTORY UPDATE

*Recall Health History Update forms are required for **all** appointments and **each** patient being seen.

Patient Name_____D.O.B_____

1. What is your current address?

_____
Street City ST Zip

2. What is your best contact number? Email address?

(_____)_____ _____

3. List all medical conditions and medications:

_____

4. List all allergies:

_____

5. What is your current insurance information?

_____
Insurance Company Name Policy Holder Name D.O.B

_____
Employer SSN#/ID# Insurance Phone#

***Insurance amounts are based upon insurance estimates. They are provided as a courtesy. In the event that your insurance carrier pays less than the estimated amount, you are responsible for the unpaid balance.**

***Any scheduled appointment that is not cancelled or rescheduled within 24 hours may be subject to a $35 charge. Three (3) broken appointments will result in dismissal from the practice.**

_____ _____ _____ _____
Legal Guardian Signature Print Name Relationship to Patient Date