

PERRY L. JEFFRIES, DDS and ASSOCIATES, PA Dr. P.L. Jeffries and Associates, PA **DENTISTRY for KIDS**

Medical History Update

Patient's Name	DD YY
Parent/ Guardian Email address: Street	
Street City State Zip Code School Grade Do you have dental insurance: Y/N Medicaid: Y/N Do you have more than one dental insurance: Y Payment of Professional Fees: The policy of payment for dental services in this office will be MasterCard. Payment is expected the day that services are rendered. Portions of the bill not insurance or Medicaid are the responsibility of the parent/legal guardian and are due in full dental visit. The parent must provide proper identification and the dental insurance and/or M day of the visit. I (Print Name) understand and agree to these terms ASSIGNMENT AND RELEASE: I, the undersigned certify that I and or my dependent(s), have insurance coverage with Associates, PA and I am financially responsible for non-covered services and charges whether or not paid by my the use of my signature on all insurance information. I also authorize Perry L Jeffries, DDS and Associates, PA / PL Je Associates, PA fo release any information required in the processing of this claim and all future claims. If my acco collection agency, I agree to pay all collection and attorney fees. Signature Date Relationship to the Patient Y N ? Explain Y N ? Explain Heart Murmur Skin Problems Anemia Rheumatic Fever Tonsil/Adenoid Problems Anemia Blood Transfusion AnDS or HIV Arthritis Tuberculosis Cancer Liver Disease Cerebral Palsy Kidney Disease Diabetes Autism Cleft Lip Speech Problems If yes to any above, please explain Is your child taking any medication at this time? (please list)	
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City State Zip Code	
School	
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Tuberculosis Cancer Liver Disease Cerebral Palsy Kidney Disease Seizures Diabetes Autism Asthma Cleft Lip Speech Problems If yes to any above, please explain Is your child taking any medication at this time? (please list)	
Liver Disease Cerebral Palsy Kidney Disease Seizures Diabetes Autism Asthma Cleft Lip Speech Problems If yes to any above, please explain Is your child taking any medication at this time? (please list)	
Kidney Disease Diabetes Autism Asthma Cleft Lip Speech Problems If yes to any above, please explain Is your child taking any medication at this time? (please list)	
Diabetes Autism Asthma Cleft Lip Speech Problems If yes to any above, please explain Is your child taking any medication at this time? (please list)	
Asthma Cleft Lip Speech Problems If yes to any above, please explain Is your child taking any medication at this time? (please list)	
Speech Problems If yes to any above, please explain Is your child taking any medication at this time? (please list)	
If yes to any above, please explain	
Name of Patient's Primary Physician Last Exam Date Allergies (please list)	