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

Medical History Update

First Last MM DD YY

Patient's Name ______________________ Sex: Male/Female Date of Birth__________

Parent/Guardian Home Phone#____________ Parent/Guardian Cell Phone# ____________

Parent/ Guardian Email address:______________________________

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/N

Payment of Professional Fees: The policy of payment for dental services in this office will be cash, check, Visa or MasterCard. Payment is expected the day that services are rendered. Portions of the bill not covered by dental insurance or Medicaid are the responsibility of the parent/legal guardian and are due in full at the time of each dental visit. The parent must provide proper identification and the dental insurance and/or Medicaid card on the 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 ______________________ and I hereby authorize my insurance benefits to be paid directly to Perry L Jeffries, DDS and Associates, PA / PL Jeffries, DDS and Associates, PA and I am financially responsible for non-covered services and charges whether or not paid by my insurance. I authorize the use of my signature on all insurance information. I also authorize Perry L Jeffries, DDS and Associates, PA / PL Jeffries, DDS and Associates, PA to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

Signature ______________________ Date ______________
Relationship to the Patient______________________

	Y	N	?	Explain		Y	N	?	Explain
Hearing Problems					**Problems at birth**				
Eye Problems					**Heart Murmur**				
Skin Problems					**Rheumatic Fever**				
Tonsil/Adenoid Problems					**Anemia**				
Emotional/Behavioral Problems					**Sickle Cell Anemia**				
Attention Deficit Disorder					**Bleeding/Hemophilia**				
Hepatitis					**Blood Transfusion**				
AIDS or HIV					**Arthritis**				
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) ______________
Name of Patient's Primary Physician ______________ Last Exam Date __________
Allergies (please list) ______________________

Medical and Dental History Reviewed By: ______________________ Date: __________