Arcadia Dental
620 Old West Central Street
Franklin MA 02038

(508)541-7400

Patient Information

Patient Name: ____ Date:
____
Last First MI (Preferred Name)

HEALTH HISTORY UPDATE

Are there any changes or new medical conditions since your last visit? ☐ Yes ☐ No
If yes, please specify:
____
____
____

Are there any new or different medications or prescriptions that you are currently taking? ☐ Yes ☐ No
If yes, please list:
______________________________ ______________________________
____
______________________________ ______________________________
____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:
____
____
____

DENTAL INSURANCE UPDATE

Has your dental coverage/policy changed since your last visit? ☐ Yes ☐ No
If yes, please specify:

Insurance Information

Primary
Name of Insured: ____ is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _________________ ID #: _____________________ Group #: _______
Insured's Address: ____
Street City State Zip Code
Insured's Employer Name: ____
Address: ____
Street City State Zip Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ___________________
Insurance Plan Name and Address: _
____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor and/or hygienist at the next appointment without fail.

____ Date: ___________________________
Signature of patient, parent or guardian

____ Date: __________________________
Signature of Provider