INFORMATION UPDATE

To assist us in keeping your child's records current, please answer the following questions below.

Please complete every 6 Months – Thank You!

Patient's Name: ____ Date of Birth: _________________ Gender: ___M ___F

Parents Full Name: ____ Email Address: _____________________________________

Address: ____

Street, City, State, Zip

Home Phone: ________________________ Cell Phone: ________________________ Work Phone: ______________________________

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with ___________________________ and assign directly to Dr. Jackson and associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signature of Parent/Guardian: ____ **Date:** _________________________

Please Print Name: ____ **Relationship to Patient:** ________________________

Name of Insurance Company: ______________________________________ **Member ID Number:** ________________________

(Please give a copy of your insurance card to the receptionist)

Street Address: _________________________________ City/State/Zip: _______________________________ Phone Number: ______________________

Subscriber Name: ___________________________________ Social Security Number: ___________________________ Date of Birth: __________________

Insured's Employer: ____

Name of Secondary Dental Insurance Company (If Applicable): ___________________________________ **Member ID Number:** ______________________

(Please give a copy of your insurance card to the receptionist)

Street Address: _________________________________ City/State/Zip: _______________________________ Phone Number: ______________________

Subscriber Name: ___________________________________ Social Security Number: ___________________________ Date of Birth: __________________

Insured's Employer: ____

Please check ALL that pertain to your child:

____ Heart Murmur/Congenital Heart Defect ____ Sickle Cell Anemia/Hemophilia ____ Allergies

____ Rheumatic Fever/Scarlet Fever ____ Epilepsy/Seizures ____ AIDS/HIV Positive/Exposure

____ ADD/ADHD ____ Behavioral/Learning Disorder ____ Asthma

____ Other (Please Explain): ____

Is your child currently taking medication: Yes / No, if yes please list:____

Has your child been hospitalized within the past year: Yes / No, if yes, please explain:____

Is there any other medical information we should be aware of: Yes / No, if yes, please explain:____

Patient's Pediatrician: ____ Date of Last Exam: ________________________

Address: ____ Phone Number: ___________________________

I certify that the above information is true and correct to the best of your knowledge, also there is no court order now in effect that prohibits me from signing this consent. I understand that it is my responsibility to inform the doctor if my minor/child ever has a change in health. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and the administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Who is accompanying the child today: ____ Relationship to Child: ____________________________

Parent/Guardian Signature: ____