Goshen Dental Health

Dr. Thomas C. Watson, D.M.D & Associates
1450 E. Boot Road, West Chester, PA 19380
610-692-8922 - Fax#610-692-4121

UPDATE FORM

Patient Name:_____ _____ _____
First M. Last

Gender: _____Male _____Female

Family Status: _____Married _____Single _____Child _____Other

Birth Date: _____

SS#: _____

Email: _____

Home #: _____ **Cell #**:_____

Address: _____

_____

_____ _____ _____
City **State** **Zip code**

Please List Current Medications: _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you Pre-Medicate: _____**Yes** _____**No**

_____**Amoxicillin** _____**Clindamycin**

Do you take a Blood Thinner (Anti-coagulant) _____**Yes** _____**No**

Name of Blood Thinner being taken: _____

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Medical History (check all that apply):

___Pre-Med Amoxicillin
___Pre-Med Biaxin
___Pre-Med Clindamycin
___AFIB
___Allergies-Seasonal
___Anemia
___Anxiety
___Arthritis/Rheumatism
___Artificial Joints
___Asthma
___Blood Clots
___Blood Disease
___Blood Thinner
___Cancer
___Celiac Disease
___Cerebral Palsy
___Diabetes
___Dialysis
___Dizziness/Fainting
___Epilepsy/Seizures
___Excessive Bleeding
___GERD
___Glaucoma
___Growths/Tumors
___Head Injuries
___HEART ATTACK
___Heart Disease
___Heart Murmur
___Hepatitis
___High Blood Pressure
___High Cholesterol
___HIV/AIDS
___Jaundice
___Kidney Disease
___Liver Disease
___Mental Disorders
___Mersa
___Migraine
___MVP-Mitral Valve Pro
___Multiple Sclerosis
___Nervous Disorders
___Pacemaker
___Parkinson
___Pregnancy
___Radiation Treatment
___Recovering Addict
___Respiratory Problems
___Rheumatic Fever
___Scoliosis Surgery
___Sezary Syndrome
___Sinus Problems
___STD
___Stomach Prob/Ulcers
___Stroke
___Thyroid
___TMJ
___Tuberculosis
___Tumors
___OTHER
____Autism
____Spectrum
____Dementia
___Alzheimer

Please add if Medical issue is not listed: _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Patient Signature Date:

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As a condition of your treatment by this office, financial agreements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatments.
All emergency dental services, or any dental services performed without previous financial agreements, must be paid for in cash at the time of service.
Patients who carry Dental Insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. The office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
I hereby authorize any provider, insurer or organization to release any information regarding dental history, treatment or benefits payable for claims to plan administrators or the authorized agent for purposes of determining benefits payable. I hereby authorize payment directly to the Dentist for the dental benefits otherwise payable to me.
A service charge of 1.5% per month (18% per annual) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
I understand that the fee estimate listed for this dental care can only be extended for a period of 6 months from the date of patient examination.
In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor or his assignees at the time said services are rendered, or within 5 days of billing if credit should be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing within the time of payment thereof. I further agree that a waiver of any breach of any costs and reasonable attorney or court fees if should be rendered hereunder.
I grant my permission to you or your assignees to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Print Name (patient, parent or guardian): _____ Date:_____

Signature (patient, parent or guardian):_____

Signature (guarantor of payment/responsible party):_____Date:_____

Appointment Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 48 hours in advance. Our doctors and Hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. ***There may be a fee of $35.00 assessed if we do not receive a call to cancel an appointment.*** Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

Signature:_____ Date:_____

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Medication Allergy (please check if you are allergic to the following):

Penicillin Allergy	_____	Sulfa Allergy	_____
Latex Allergy	_____	Dental Anesthesia	_____
Clindamycin Allergy	_____	Codeine	_____
Tetracycline	_____	Erythromycin	_____
Aspirin Allergy	_____	Dental Anesthetics	_____

Other Allergies:_____ _____ _____