Patient's Last name: _____ First: _____ Middle:_____

Marital status: ( )Single ( )Mar ( )Div ( )Sep ( )Wid

Street address: _____

_____

Cell phone #: _____Home phone #:_____Email: _____

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last appointment?_____

_____

Are you taking any kind of medication at this time?_____

If yes, please list them:_____

Do you have any new allergies to medications? ( )Yes ( ) No

If yes, please list them:_____

Name of Pharmacy:_____ Pharmacy phone #:_____ Location_____

Women: Are you pregnant? ( ) Yes ( )No

Due Date:_____ Please have your OB doctor fax a letter to our office stating it is OK for you to be seen and have any needed treatment. Fax # 843-766-0849

INSURANCE INFORMATION UPDATES

Subscriber Name: _____Subscriber DOB: _____Subscriber SS#: _____

Subscriber Employer:_____ Insurance Co: _____ID#_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Krisitn Saville, DDS, PC. I understand that I am financially responsible for any balance. I also understand that claims are filed as a courtesy and it is my responsibility to know my dental benefits.

_____

Patient/Guardian Signature Date

Kristin M. Saville, DDS, PC
2060 Charlie Hall Blvd, Suite B
Charleston, SC 29414
843-766-0266