PATIENT UPDATE

Date _____

Patient's Name _____ Sex: M F Birthdate _____
First Middle Last

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ **E-mail:** _____

Patient Employed By: _____ How Long? _____

MEDICAL HISTORY

Physician's Name: _____ Last Seen: _____

Physician's Phone Number: _____

Have you had any serious illness or operations? ❑ Yes ❑ No When? _____

If yes, describe _____

Women: Are you Pregnant? ❑ Yes ❑ No If yes, Due Date _____

OB/GYN _____

Nursing? ❑ Yes ❑ No Are you currently taking Birth Control Pills? ❑ Yes ❑ No

Check ONLY if YES to the following:

❑ Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?

❑ Do you use Tobacco in any form? If yes, explain what form & how often. _____

❑ Do you consume more than (2) alcoholic beverages a day?

❑ No Change INSURANCE UPDATE

Dental Insurance Information (Primary Carrier)

Insured's Name: _____ Relationship: _____

Insured's Employer: _____

Insurance Company: _____

Insurance Company's Address: _____

Insurance Phone Number: _____

Social Security #: _____ Birthdate: _____

Group # _____ Insured's I.D. #: _____

Dental Insurance Information (Secondary Carrier)

Insured's Name: _____ Relationship: _____

Insured's Employer: _____

Insurance Company: _____

Insurance Company's Address: _____

Insurance Phone Number: _____

Social Security #: _____ Birthdate: _____

Group # _____ Insured's I.D. #: _____

Check ONLY if YES to the following:

- ❑ Anemia
- ❑ Arthritis/rheumatism
- ❑ Artificial joints
- ❑ Asthma:
- ❑ Required hospitalization
- ❑ Steroids needed
- ❑ Last episode _____
- ❑ Bleeding abnormally with extractions / surgery
- ❑ Blood disease / clotting disorders
- ❑ Blood thinners
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory problems
- ❑ Cortisone treatments
- ❑ Cough, persistent / bloody
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ High blood pressure

Heart:

- ❑ Artificial heart valve
- ❑ Heart Lesions (congenital)
- ❑ Heart problems
- ❑ Heart surgery
- ❑ Mitral valve prolapsed
- ❑ History of Endocarditis
- ❑ Pacemaker
- ❑ Stroke
- ❑ Hepatitis - type _____
- ❑ Herpes
- ❑ HIV / AIDS
- ❑ HPV (human papilloma virus)
- ❑ Immune deficiency (any)
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Osteoporosis
- ❑ Radiation treatment
- ❑ Respiratory problems
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Sinus allergies
- ❑ Slow healing wounds
- ❑ Swelling feet / ankles
- ❑ Thyroid problems
- ❑ Tuberculosis
- ❑ Tumors / growths on the head / neck
- ❑ Venereal disease
- ❑ Weight loss, unexplained

Check ONLY if you are ALLERGIC or have ever experienced any reaction to the following?

- ❑ Aspirin
- ❑ Codeine
- ❑ Erythromycin
- ❑ Latex
- ❑ Local anesthetics (novocaine)
- ❑ Motrin
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline
- ❑ Tylenol

Any other allergies:

_____

_____

_____

_____

List ALL Medications you are currently taking & what they're used for:

_____

_____

_____

_____

Have you Ever taken any of the following medications?

Actonel Aredia Fosamax Reclast Zometa Boniva

Consent:

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health or a change in my medication, I will inform the dentist at my next appointment.

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatments, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

Signature of Patient

_____ Date _____

(Parent / Guardian if child)