PATIENT INFORMATION UPDATE

Patient Name:____ Male:_____ Female:_____

Birthdate: ________________ Social Security Number: ______________________________

Address: _________________________ City: ___________________ State: ___________

Phone#:_________________________ Work#:___________________ Ext:____________

Emergency Contact Name: ______________________________ Phone#: _______________

Cell#:___________________ Pager#: __________________ E-Mail:___________________

PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN PATIENT:

Name: _________________________________ Relationship: __________________________

Birthdate: ___________________ Social Security Number: _____________________________

Address (if different): __________________________ City: _______________ State:________

Phone#: _______________________ Work#: ___________________ Ext: ________________

Employer: _________________________ Address: ___________________________________

Email Address: ____

PRIMARY INSURANCE POLICY HOLDER:

Name: ____________________________ Relationship to patient: ________________________

Birthdate: ___________________ Social Security Number: ____________________________

Employer: _________________________ Address: __________________________________

Group/Policy#: _______________________ Insurance Company: ________________________

SECONDARY INSURANCE POLICY HOLDER:

Name: ____________________________ Relationship to patient ________________________

Birthdate: ___________________ Social Security Number: ____________________________

Employer: _________________________ Address: __________________________________

Group/Policy#: _______________________ Insurance Company: ________________________

MEDICAL HISTORY

Patient Name: ____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes	☐ No	☐ N/A	
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	☐ N/A	______________________
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	☐ N/A	______________________
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	☐ N/A	______________________
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	☐ N/A	**Do you use tobacco?** ☐ Yes ☐ No ☐ N/A
Are you on a special diet?	☐ Yes	☐ No	☐ N/A	**Do you use controlled substances?** ☐ Yes ☐ No ☐ N/A

Women: Are you ☐ **Pregnant / Trying to get pregnant?** ☐ **Nursing** ☐ **Taking oral contraceptives**

Are you allergic to any of the following?

☐ **Aspirin** ☐ **Penicillin** ☐ **Codeine** ☐ **Acrylic** ☐ **Metal** ☐ **Latex** ☐ **Local Anesthetics** ☐ **Other** ________________________

Do you have, or have you had, any of the following?

☐ Aids/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeats	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack / Failure	☐ Low Blood Pressure	☐ Spinal Bifida
☐ Arthritis / Gout	☐ Diabetes	☐ Heart Murmur *	☐ Lung Disease	☐ Stomach / Intestinal Disease
☐ Artificial Heart Valve *	☐ Drug Addiction	☐ Heart Pace Maker *	☐ Mitral Valve Prolapse *	☐ Stroke
☐ Artificial Joint *	☐ Easily Winded	☐ Heart Trouble / Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problems	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells / Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever *	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ **Yes** ☐ **No** ☐ **N/A** ________________________________

Comments:____

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*** Conditions may require medication** **N/A – Not answered by patient**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

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SIGNATURE OF PATIENT, PARENT, or GUARDIAN **DATE**