Patient Update

Patient Information

Name:_____ Date:_____

Mailing Address:_____ City_____ Zip Code_____

Employer:_____ Work Phone:_____

Cell Phone:_____ Home:_____ Email Address:_____

Dental Insurance Information

Name of person responsible for insurance:_____

Relationship to patient:_____ Birth date:_____ Social Sec #_____

Person responsible employer:_____ Business Address:_____

Name of insurance company:_____ Group #_____

Id #_____ Insurance Address:_____

Insurance phone #_____ Additional dental insurance coverage: Y N (circle one)

Health History

Physicians Name:_____ Phone:_____ Date of last exam:_____

Are you being treated for a current medical condition? **Y N** *List condition*:_____

Do you Smoke/Chew? **Y N** please circle **SMOKE OR CHEW**

Have you had any serious illness or operations? **Y N** *Describe*:_____

Have you experienced allergies to **latex, ibuprofen, codeine, penicillin, sulfa drugs, metal, or local anesthetics**? **Y N** If yes, circle which one.

List current medications you are taking:_____

Are you currently taking **Bisphosphonates**? **Y N** (circle one) If yes, (**✓**) what? Fosamax ☐ Boniva ☐ Aredia ☐ Actenol ☐

MALE: Currently taking any ED medications? **Y N** (circle one) If yes, (**✓**) what? Viagra ☐ or Cialis ☐

FEMALE: Are you pregnant or do you think you are pregnant? **Y N** Are you currently taking Birth Control? **Y N**

ALL PATIENTS: Circle Y if it applies

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

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.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN_____ DATE_____