

Patient Information Update

You have been to our office before, but information changes frequently. Please take a few minutes to review the following information, make any necessary changes, and answer the questions. If you provide us with an e-mail address that you check frequently, we'll send appointment reminders to you electronically.

Name
Address
City

Home phone:
Work phone:
Work phone2:
e-mail:
Occupation:

(Please circle the
best number for
us to call you.)

Any change in your marital status? (If so, what?) _____

Please carefully review this insurance information and update it if necessary. If we don't have accurate information, your claims may be delayed.

Primary coverage

Secondary coverage

Insured Party:
Employer/plan:
Insurance company:

Medical History / Information

Emergency contact name and phone(s):

Physician's name, city and phone:

List all medications you are currently taking, and why you are taking them:

Allergic to: ___ Latex ___ Codeine ___ Antibiotics (list below) ___ Dental anesthetics (list below)

List any other allergies:

Any hospitalizations, serious illness or change in health status since your last visit (on ___)? Yes / No

If yes, please describe: _____

Are you pregnant or nursing? Yes / No Are you taking birth control pills? Yes / No

Do you smoke? Yes / No Are you diabetic? Yes / No

Do you get headaches? Yes / No Frequency? _____ Severity? _____

Do you have any of these heart problems? (circle all that apply) Mitral valve prolapse Heart murmur
Congenital heart defect Artificial valve History of heart attack High blood pressure

Do you have any artificial joints? Yes / No (details) _____

Is there anything you want to talk to the doctor about today? _____

All of the information above is true and correct _____

Patient, Parent or Guardian signature

Date