FAMILY DENTISTRY

Today's Date: _____

UPDATED PATIENT INFORMATION

Patient Name: _____ Date of birth: _____ Sex: _____ Age:_____

Home Address: _____ City:_____ State: _____ Zip: _____

Home Phone:_____ Cell:_____ Email: _____

Single _____ Married____ Dependent_____ Employer/Occupation:_____

Has your dental insurance changed the past year? YES NO

If you answered yes, please list new insurance(s):

Primary dental insurance: _____ Group #:_____

Subscriber's Name:_____ Date of birth: _____ SS#:_____

Secondary dental insurance: _____ Group #:_____

Subscriber's Name:_____ Date of birth: _____ SS#:_____

Name of your medical doctor: _____ Are you under the care of a physician now? _____

If so, for what reason? _____

Please list daily medications:_____

Have you ever had the following? (Please circle yes or no)

Allergies to latex	YES	NO	Heart Murmurs	YES	NO
Allergies to penicillin	YES	NO	High Blood Pressure	YES	NO
Allergies to other medicines	YES	NO	HIV (AIDS)	YES	NO
Please list below:			Hepatitis	YES	NO
_____			Implants (joint, heart, valves, etc)	YES	NO
Asthma	YES	NO	Cancer	YES	NO
Diabetes	YES	NO	Stroke	YES	NO
Epilepsy	YES	NO	Tendency to bleed	YES	NO
Heart Disease	YES	NO	Tuberculosis	YES	NO
Premedication required by physician	YES	NO	Are you pregnant?	YES	NO

If yes, please explain: _____

Are you apprehensive about dental treatment? YES NO Are you interested in teeth whitening? YES NO

Do you use any tobacco products? YES NO

I understand the information I have given today is correct to the best of my knowledge. I understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical/dental status. I also understand that I am responsible for payment of services rendered, and for paying any co-payment and deductible that my insurance does not cover.

Signature: _____ Date:_____