PATIENT UPDATE FORM

Date: _____

Patient Information:

Last Name:_____ First Name:_____Middle:_____
Address:_____Apt #_____
City:_____ State:_____ Zip code:_____
Mobile Phone:_____ Work Phone:_____ Home Phone:_____

1. How would you like to receive your appointment reminders? (Check all that apply)
   Telephone (☐ Mobile ☐ Work ☐ Home) ☐ Text ☐ Email_____

2. Any change in **insurance** coverage? ☐Yes ☐No *If yes, please complete below:*

Primary Insurance:	Secondary Insurance:
Subscriber Name: _____	Subscriber Name: _____
Subscriber ID: _____	Subscriber ID: _____
Social Security #: _____	Social Security #: _____
Relationship to Patient: _____	Relationship to Patient: _____
Employer Name: _____	Employer Name: _____
Employer Phone: _____	Employer Phone: _____
Insurance Company: _____	Insurance Company: _____
Insurance Group #: _____	Insurance Group #: _____
Insurance Phone: _____	Insurance Phone: _____

3. Do you require **pre-medication** before dental procedures? ☐Yes ☐No
   If yes, did you take your pre-med today? ☐Yes ☐No
   Preferred **Pharmacy:** _____ **Phone:** _____

ALLERGIES:

4. Are you allergic or sensitive to: ☐No Allergies ☐Penicillin ☐Sulfa Drugs ☐Erythromycin ☐Aspirin ☐NSAID ☐Codeine ☐Local Anesthetics ☐Latex ☐Nuts ☐Coconut ☐Metals _____ ☐Other _____

MEDICAL HISTORY:

5. Physician's Name: _____ Phone: _____
6. Date of last physical exam: _____
7. Are you currently under the care of a physician? ☐ Yes ☐ No
   If yes, for what reason(s)? _____

4. Please list any **MEDICATIONS** / **VITAMINS** / **HERBALS** / **SUPPLEMENTS** that your are currently taking.

_____ _____

_____ _____

_____ _____

_____ _____

Blood thinner? _____ Bisphosphonate? _____

6. Do you smoke, chew or use E-Cigarettes? ☐ Yes ☐ No

7. Do you have diabetes? ☐ Yes ☐ No Do you take insulin? ☐Yes ☐No

Last HbA1c date and level: _____

8. Do you have, or have you ever had:

Heart murmur	☐ Y ☐ N	Bleeding disorders	☐ Y ☐ N
Heart surgery	☐ Y ☐ N	Thyroid problems	☐ Y ☐ N
Heart stint	☐ Y ☐ N	Hepatitis A B C or other liver disease	☐ Y ☐ N
Rheumatic fever	☐ Y ☐ N	Cancer	☐ Y ☐ N
Artificial heart valve / stint	☐ Y ☐ N	Chemotherapy	☐ Y ☐ N
High blood pressure	☐ Y ☐ N	Arthritis	☐ Y ☐ N
Stroke / TIA's	☐ Y ☐ N	Artificial joint replacements	☐ Y ☐ N
Ulcers / GERD	☐ Y ☐ N	HIV positive / AIDS	☐ Y ☐ N
Kidney trouble / Dialysis	☐ Y ☐ N	Chemical dependency	☐ Y ☐ N
TB or lung disease	☐ Y ☐ N	Glaucoma	☐ Y ☐ N
Asthma	☐ Y ☐ N	Treatment with Bisphosphonates?	☐ Y ☐ N
Epilepsy / Seizures	☐ Y ☐ N	For Women:	
Fainting spells / Dizziness	☐ Y ☐ N	Are you pregnant? Due Date: _____	☐ Y ☐ N
Anemia	☐ Y ☐ N	Are you nursing?	☐ Y ☐ N
Leukemia	☐ Y ☐ N	Do you take oral contraceptives?	☐ Y ☐ N

9. Do you have any **medical implants** or prosthetic joints? ☐ Cochlear Implant ☐ Pacemaker ☐ Insulin Pump ☐ Joint Replacement ☐ Cardiac Stint

10. Have you had any other serious illness, hospitalization, or accident? ☐Yes ☐No
If yes, please explain: _____

Staff Notes:

_____

_____

AUTHORIZATION:

I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications and/or drugs (including recreational and over the counter) that I am taking or have taken in the last week.

I consent to the release of information concerning my (or my child's) healthcare, treatment or advice to another dental or healthcare professional, for evaluating treatment or for the purpose of administering or filing claims for insurance benefits. I understand that my insurance benefits may pay less than the actual fees for services and that I am responsible for any services not covered by my insurance.

Signature _____ Print Name _____
(Responsible Party if under 18)