PATIENT UPDATE

DATE: ______________

1. PATIENT INFORMATION

Patient Name: ______________________________ Birthday: ______________

If child- parent name: ______________________________

Address: ______________________________

City: ______________________ State: ________ Zip: ____________

Home Phone: ____________________ Cell Phone: ____________________

Employer: ______________________________ Work Phone: ______________

Social Security Number: ______________________________

Marital Status: ____ Single ____ Married ____ Divorced ____ Separated ____ Widow

Emergency Contact: ______________________ Daytime Phone: ______________

2. HEALTH INFORMATION

Last Physical Exam: ______________ Physician's name: ____________________

City, State: ______________________ Phone: ____________________

Current Medications: ____

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Do you pre-med before dental appointments? Y N

Do you have:

- ____ Heart Condition
  - ____ Rheumatic Fever
  - ____ Heart Murmur
  - ____ Other
- ____ AIDS/HIV
- ____ Asthma
- ____ Cancer / Tumors
- ____ Cold Sores
- ____ Deafness
- ____ Diabetes
- ____ Epilepsy / Seizures
- ____ Fever Blisters
- ____ Hepatitis
- ____ Herpes I or II
- ____ Joint Replacement
- ____ Low / High Blood Pressure
- ____ Nervous Problems
- ____ Pregnant (currently)
- ____ Prolonged Bleeding
- ____ Psychiatric Care
- ____ Radiation Therapy
- ____ Tuberculosis

ALLERGIES:

- ____ Aspirin
- ____ Novocain
- ____ Sulfa Drugs
- ____ Penicillin
- ____ Amoxicillin
- ____ Codeine
- ____ Other

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Any other medical conditions the doctor should know about? ______________________

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(please complete #3 on the back side)

3. INSURANCE INFORMATION:

Dental Insurance Company: ______________________________ Phone: ______________________

Address: ____

City: ______________________________ State: __________ Zip: ______________

Insured: Name: ______________________________ Relationship to Patient: __________

Employer: ____

Social Security # or Card ID #: ______________________ Group # ______________

Patient's Birthday: ______________________

Signature: ______________________________________ Date: ______________________
(Parent/Guardian if patient is a minor)

Date: ______________________

Changes: ____

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Signature: ____________________________________

Date: ______________________

Changes: ____

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Signature: ____________________________________

Date: ______________________

Changes: ____

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Signature: ____________________________________