# UPDATE

**DATE:**_____

☐ **New Address** ☐ **New Phone** ☐ **New Insurance**

PATIENT'S
NAME: _____
Last First Initial

IF CHILD:
PARENT'S NAME _____
Last First Initial

**DATE OF BIRTH:** _____

PATIENT'S SSN: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PATIENT/PARENT EMPLOYED BY: _____

SPOUSE/PARENT NAME: _____

SPOUSE/PARENT EMPLOYED BY: _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT?

_____

PHYSICIAN'S NAME _____

ADDRESS _____

CONTACT IN CASE OF EMERGENCY _____

PHONE # _____

## PATIENT CONTACT INFORMATION

HOME PHONE #: _____

CELL PHONE #: _____

WORK PHONE #: _____

PARENT CONTACT PHONE # (MINOR): _____

HOW WOULD YOU LIKE US TO CONTACT YOU?

☐ HM. PHONE ☐ CELL ☐ EMAIL ☐ TEXT

**EMAIL:** _____

### DENTAL INSURANCE

EMPLOYEE NAME: _____

EMPLOYEE DATE OF BIRTH: _____

NAME OF INSURANCE CO.: _____

TELEPHONE: _____

EMPLOYEE ID: _____

GROUP #: _____

EMPLOYEE SSN: _____

☐ **DENTAL INSURANCE - 2ND COVERAGE (SEE BACK)**

# Medical History

**Please answer each question. Circle YES or NO where applicable.**

Yes No 1. Are you in good health?

2. Date of last physical examination _____

Yes No 3. Are you now under the care of a physician?

Yes No 4. Have you ever had any serious illness?
If so, what illness? _____

Yes No 5. Have you ever been hospitalized or had an operation?
If so, what was the problem? _____

Yes No 6. Have you had heart surgery? Wear a pacemaker/defibrilator?

Yes No 7. Do you have any disease, condition or problem not listed above that you think we should know about?
If so, explain? _____
_____

Yes No 8. (Women) Are you pregnant?

Yes No 9. Are you allergic to any foods? If so please list
_____

Yes No 10. Are you sensitive or allergic to any drugs?
If so, please list: _____
_____

Yes No 11. Are you taking Vitamins or Herbs? If so, Please list:
_____

Yes No 12. Are you taking any drugs or medicine?
* If so, please list: _____
_____

* Continue list on back

**Do you have, or have you had any of the following:**

☐ Latex allergy
☐ Anemia
☐ Heart Ailments
☐ Mitral Valve Prolapse
☐ Heart Murmur
☐ Heart Defibrilator
☐ Heart Pacemaker
☐ Artificial Heart Valve
☐ Rheumatic Fever
☐ High Blood Pressure
☐ Stroke
☐ Respitory / Pulmonary Disease
☐ Tuberculosis
☐ Nervous Disorders
☐ Diabetes
☐ Excessive Bleeding
☐ Blood Diseases
☐ Hepatitis, jaundice/liver disease
☐ Kidney Diseases
☐ Tumors or Growths
☐ Radiation treatment of any kind
☐ Chemotherapy
☐ Allergies/Hay Fever
☐ Asthma
☐ Fainting spells or seizures
☐ Sinus trouble
☐ Blood Transfusion
☐ Artificial Joint/Metal Implant
☐ AIDS or ARC
☐ HIV Positive
☐ Drug Addiction
☐ Alcohol Abuse/Addiction
☐ Tobacco Use
☐ Recovery Program
☐ Dry Mouth
☐ Rheumatism or Arthritis
☐ Head Injuries
☐ Stomach ulcers
☐ Venereal Disease
☐ Epilepsy
☐ Mental Disorders
☐ Glaucoma
☐ Bad Breath

**Signature** _____

# DENTAL INSURANCE - 2ND COVERAGE

EMPLOYEE NAME: _____

EMPLOYEE DATE OF BIRTH: _____

NAME OF INSURANCE CO.: _____

TELEPHONE: _____

EMPLOYEE ID: _____

GROUP #: _____

EMPLOYEE SSN: _____