Patient Information Update Slip

In order for us to provide you with the best possible service we need to have updated information as well as any changes in your medical history. Please fill out the form below so our records will be correct. Sign and date the bottom of this form in the space provided.

Name: __________________________________ DOB: _________ SS#:________________________

Address: _________________________________ City: __________________ St: ____ Zip: ___________

Home Phone: ______________________ Cell Phone: ____________________ Work Phone: ________________

Email: _______________________________________ Dental Insurance: _________________________

Dental Insurance Member ID Number: _____________________ Insurance Phone: ___________________

Person Responsible For Account: ____________________________ Phone: _______________________

Emergency Contact: __________________________________ Phone: _______________________

Medical History – if "no" please be sure to mark no

1.) Are you currently under the care of a physician? ☐ Yes ☐ No

Physicians Name: ______________________________ Phone: ___________________

2.) Are you taking any medications ☐Yes ☐No ***Please list all medications***: ___________________________

____

3.) Are you allergic to any of the following: ☐Penicillin ☐Latex ☐Sulfur ☐Codeine ☐Dental Anesthetic

Other Allergies: ____

4.) Are you nursing or pregnant: ☐Yes ☐No (***If yes, please circle which one***)

5.) Has your physician ever informed you that you have or had:

☐High Cholesterol	☐Liver Disease	☐AFIB	☐Psychiatric Care
☐High Blood Pressure	☐Kidney Disease	☐Diabetes	☐Fainting / Dizziness
☐Low Blood Pressure	☐Epilepsy / Convulsions	☐Cold Sores	☐Venereal Disease
☐Respiratory Disease	☐Tumors or Growths	☐Glaucoma	☐Asthma
☐Stomach Problems	☐Intestinal Disease	☐TB	☐ Sleep Apnea
☐Thyroid Disease	☐ HIV+ / AIDS	☐Hepatitis	
☐ Goiter	☐Abnormal bleeding	☐Fainting / Dizziness	
☐Anemia	☐Blood Disease	☐ Osteoporosis	
☐Leukemia	☐Pacemaker	☐Anxiety/Nervous Disorders	
☐ Arthritis	☐Heart Disease	☐ Heart Murmur	

Date occurred:

☐ Heart Attack ____________

☐Mitral Valve Prolapse ___________

☐Open Heart Surgery ____________

☐Stroke___________

☐ Cancer ____________ Active: Y N

Frequency:

☐ Tobacco Use _______________

☐Alcohol Use _______________

☐Recreational Drug Use ____________

☐ Joint / Valve / Organ / Replacement: Type: _____________________ **Pre-med Required?** ☐ Yes ☐ No

Any additional medical information: ____

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____ _________________________

Signature of Patient or Guardian Date

____

***Once form is complete**, please review the above information once a year and make any necessary changes and sign below.*

☐ No Changes ☐ Changes Noted ____________________________ ____________

Signature of Patient or Guardian Date

☐ No Changes ☐ Changes Noted ____________________________ ____________

Signature of Patient or Guardian Date