



In order for our office to provide you better quality care and service, we require this form to be updated yearly.

PATIENT NAME _____ DATE _____

Social Security # _____ Date of Birth _____

Address _____ Employer _____

Phone# _____ Phone # _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

Social Security # _____ Date of Birth _____

Address _____ Phone# _____ Employer _____

Work# _____

DENTAL INSURANCE _____ Yes _____ No

Primary Secondary

Subscriber Name _____

Insurance Company _____

** In order for us to submit your claim to your insurance you must provide us with the name and address of your carrier, we will gladly make a copy of your insurance card if you have one.

MEDICAL HISTORY UPDATE

Have you been under a physician's care or hospitalized in the last 12 months? YES NO

If yes, reason? _____

Are you taking any medications, prescription or non prescription? YES NO

If yes, please list _____

Have you ever had any heart problems/surgery, heart murmur, Mitral Valve prolapse, or a pace maker? (specify) YES NO

Have you ever had an artificial joint replacement, or pin/plates in any bones? YES NO

Woman, are you currently pregnant? YES NO

Please list allergies to medications and general allergies: _____

Circle any of the following that apply to you now or in the past:

- Asthma Diabetes High Blood Pressure Lung/Breathing Problems
Blood Disorders Epilepsy/Seizures/Fainting HIV(AIDS) Sinus Trouble
Cancer Heart Problems Liver/Kidney Disease Stroke
Circulation Problems Hepatitis Low Blood Pressure
Other Serious Illness _____

Signature _____ Date _____

Notes: