PATIENT INFORMATION UPDATE

Name_____How would you like to be addressed_____

Home Address_____City/Zip_____

Birthdate_____Home Phone_____Cell Phone_____Work Phone_____

Marital Status_____Social Security Number_____

Are You Covered By Dental Insurance?___ If Yes, Name of Insurance Co._____

Subscriber's Name_____ Subscriber's Employer_____

Subscriber's Birthdate_____Subscriber Social Security Number_____

Are You Covered By A Second Insurance Co.(eg.,spouse's)____ Insurance Co._____

Subscriber's Name_____Subscriber's Employer_____

Subscriber's Birthdate_____ Subscriber's Social Security Number_____

DO YOU HAVE, OR HAVE YOU EVER HAD:

Asthma ,hay fever, sinusitis, or allergies	YES	NO
Allergy to penicillin, aspirin, local or general anesthetic or other drugs	YES	NO
Blood pressure or heart problems	YES	NO
Rheumatic fever or heart murmur	YES	NO
A pacemaker or open heart surgery	YES	NO
Diabetes, liver,kidney,thyroid or lung problems	YES	NO
Ulcers or stomach problems	YES	NO
Hepatitis or jaundice	YES	NO
Epilepsy or nervous disorders	YES	NO
Bleeding or clotting problems	YES	NO
Arthritis	YES	NO
Chronic headaches	YES	NO
Do wounds heal slowly or present complications	YES	NO
Are you presently taking any medications, If yes,please specify	YES	NO
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Are you presently under the care of a physician	YES	NO
When was your last physical exam		
Have you been hospitalized in the last two years	YES	NO
Have you had radiation treatments or chemotherapy	YES	NO
Venereal disease or herpes	YES	NO
Aids related complex or aids	YES	NO
Women: Are you pregnant or think you could be pregnant	YES	NO
Any other illness	YES	NO
Is there anything else we should know about your health	YES	NO

Signed_____ Date_____