PATIENT UPDATE

Name____ Date__________________________

Are you under a physician's care now? Yes / No Date of last physical_____________________

If yes, reason: ____

Please list **all** medication you are taking: ____

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Please List any **allergies** you have:____

Have you been hospitalized since your last visit to our office? Yes / No

If yes, reason: ____

Women Only: Are you or could you be pregnant? Yes / No If yes, what month_____________

Please circle if you have had a history of any of the following:

Heart Disease	Joint Replacement	Radiation/Chemotherapy
Heart Murmur	Diabetes (Sugar)	Blood Disease
Mitral Valve Prolapse	Thyroid issue	Cardiac Pacemaker
High Blood Pressure	Asthma	Excessive bleeding from cut
Kidney Issues	Organ Transplant	Blood Thinners

Do you smoke or use tobacco products? Yes / No

History of exposure to: Hepatitis Tuberculosis AIDS Venereal Disease

Please update the following information in full – Print Clearly

Home Address: ______________________________________ Home phone_______________________
(House number & Street)

______________________________________ Mobile phone_______________________
(City, State, Zip)

Email Address______________________________________ Work phone_______________________

Would you like reminders for your appointments via: text message email phone?
(Check all that apply)

Please list your dental insurance information:
Carrier Name_________________________________ is subscriber self / spouse / parent
Employer providing insurance__________________________ Group Number____________________
Subscriber ID#_____________________________________

SIGNATURE: ____