Patient Information Update

☐ Married ☐ Single ☐ Child **Name**:____ **Nickname**: ____________________

Address:____ **Apt#:** _________ **DOB**: _______/________/_______

City: ______________________________________ **State:** _______________________ **Zip**: _______________________

Please specify your preference below:

Contact Numbers **Home # :** ____ call 1st 2nd 3rd

Cell #: ____ call 1st 2nd 3rd

Work #: ____ call 1st 2nd 3rd

Email: ____

We remind patients of their upcoming appointments by email. This email address is for our office use only, it will not be released to solicitors.

Would you like to receive appointment reminders via text message? ☐Yes ☐ No

How would you prefer to be contacted? ____

Emergency Contact

Name:____ Relation: ___________________________________

Contact #:____ Alternate # : __________________________________

Dental Insurance: ☐ Same ☐ Different ☐ None

Subscriber's Name: ____ Subscriber's DOB: ________/________/________

Ins Co: ___________________________ Employer: __________________________ Subscriber's ID #: ___________________

Medical History – Have you ever had any of the following? **Please check those that apply:**

☐ Anemia
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Head Injuries
☐ Heart Problems
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ HIV/Aids

☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorder
☐ Mitral Valve Prolapse
☐ Nervous Disorder
☐ Pacemaker
☐ Radiation Treatment
☐ Rheumatic Fever
☐ Rheumatism
☐ Seasonal Allergies
☐ Sinus Problems
☐ Stomach Problems/Ulcers
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Venereal Disease
☐ ____________________

Surgeries: ☐ None ______________________________
____
____
____

Drug Allergies: ☐ None _________________________
____
____
____

Medications Currently Taking: ☐ None
____
____
____

Any Other Medical Info not listed above:
____
____

Have you ever been told to take Antibiotics before dental treatment? Y / N
Are you pregnant or is there a chance that you could be? Y / N Due Date:_______/_______/_______

Please remember that we require 24 hours notice to change an appt to avoid the broken appt. fee of $42.00

Signature: ____ Date: ________/________/________