

UPDATE INFORMATION FORM FOR EXISTING PATIENTS

To help us keep your records accurate and provide you with the best possible care,
please update your information below. *Thank you!*

1 PATIENT INFORMATION

Patient Name _____
Last Name First Name Middle Initial

Preferred Name _____

Date of Birth _____ SS/HIC/Patient ID # _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Email _____

Marital Status
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Employer/School _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any,
otherwise payable to me for services rendered. I understand that I am
financially responsible for all charges whether or not paid by insurance.
I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may
disclose such information to the above-named Insurance Company(ies) and
their agents for the purpose of obtaining payment for services and
determining insurance benefits or the benefits payable for related services.
This consent will end when my current treatment plan is completed or one
year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative _____

Please print name of Patient, Parent, Guardian or Personal Representative _____

Date _____ Relationship to Patient _____

3 PHONE NUMBERS

Phone (_____) _____ Work (_____) _____ Ext _____ Cell (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you
have had any of the following:

Bad breath ☐ Yes ☐ No
Bleeding gums ☐ Yes ☐ No
Blisters on lips or mouth ☐ Yes ☐ No

Burning sensation on tongue ☐ Yes ☐ No
Chew on one side of mouth ☐ Yes ☐ No
Cigarette, pipe, or cigar smoking ☐ Yes ☐ No
Clicking or popping jaw ☐ Yes ☐ No
Dry mouth ☐ Yes ☐ No
Fingernail biting ☐ Yes ☐ No
Food collection between the teeth ☐ Yes ☐ No
Foreign objects ☐ Yes ☐ No
Grinding teeth ☐ Yes ☐ No
Gums swollen or tender ☐ Yes ☐ No
Jaw pain or tiredness ☐ Yes ☐ No
Lip or cheek biting ☐ Yes ☐ No
Loose teeth or broken fillings ☐ Yes ☐ No

Mouth breathing ☐ Yes ☐ No
Mouth pain, brushing ☐ Yes ☐ No
Orthodontic treatment ☐ Yes ☐ No
Pain around ear ☐ Yes ☐ No
Periodontal treatment ☐ Yes ☐ No
Sensitivity to cold ☐ Yes ☐ No
Sensitivity to heat ☐ Yes ☐ No
Sensitivity to sweets ☐ Yes ☐ No
Sensitivity when biting ☐ Yes ☐ No
Sores or growths in your mouth ☐ Yes ☐ No
How often do you floss? _____
How often do you brush? _____

Any changes in your health since last visit? ☐ Yes ☐ No
If yes, please explain _____

Are you taking any new medications? ☐ Yes ☐ No
If yes, please list _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Head/Neck Injuries ☐ Yes ☐ No Allergic Reactions ☐ Yes ☐ No
Hospitalization ☐ Yes ☐ No Other Medical Conditions ☐ Yes ☐ No
Surgery ☐ Yes ☐ No Pregnancy ☐ Yes ☐ No

thank you!

WE LOOK FORWARD TO CONTINUING TO PROVIDE YOU WITH EXCEPTIONAL CARE.



5

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionilmin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
		Radiation Treatment	☐ Yes ☐ No		

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No

Due date _____

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No



MEDICATIONS

List any medications you are currently taking and the corresponding diagnosis:

Pharmacy Name _____

Phone (_____) _____



ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

6

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

thank you