PATIENT INFORMATION UPDATE SHEET

Date: _____

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Birthdate: _____ Social Security Number: _____
Home Phone: _____
Work Phone: _____ Employer: _____
Cell Phone: _____
E-Mail: _____

How do you prefer to be reminded of appointments? Check all that apply:
☐ Voice Message on Home Phone
☐ Voice Message on Cell Phone
☐ Text Message to Cell Phone
☐ E-mail reminder

Responsible Party

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Relationship: _____

Primary Dental Insurance Information

Policy Holder: _____ Relationship: _____
Date of Birth: _____ Soc. Sec. No.: _____
Employer: _____ Dental Insurance Carrier: _____
Group No.: _____ Contract No.: _____
** Please provide a current copy of your insurance card

Secondary Dental Insurance Information

Policy Holder: _____ Relationship: _____
Date of Birth: _____ Soc. Sec. No.: _____
Employer: _____ Dental Insurance Carrier: _____
Group No.: _____ Contract No.: _____
** Please provide a current copy of your insurance card

Patient Dental History

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing?	☐	☐	Do you bite your lips or cheeks frequently?	☐	☐
Are your teeth sensitive to hot or cold liquids/ foods?	☐	☐	Have you had any orthodontic treatment?	☐	☐
Are your teeth sensitive to sweet or sour liquids/ foods?	☐	☐	Do you wear dentures or partials?	☐	☐
Do you feel pain to any of your teeth?	☐	☐	Have you ever experienced any of the following:		
Do you have any sores or lumps in or near your mouth?	☐	☐	Clicking in your jaw	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐	Pain (jaw, joint, ear, side of face)	☐	☐
Do you have frequent headaches?	☐	☐	Difficulty in opening or closing your jaw	☐	☐
Do you clench or grind your teeth?	☐	☐	Difficulty in chewing	☐	☐

Patient Medical History

Medical Physician _____ Phone _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Are you under medical treatment now?	☐	☐	9. Women Only:		
2. Have you been hospitalized for any operation or serious illness within the past 5 years? List_____	☐	☐	a.) Are you pregnant? b.) Are you nursing? c.) Are you taking oral contraceptives?	☐	☐
3. Do you use tobacco?	☐	☐	10. Please list all medications you are currently taking:		
4. Do you use controlled substances?	☐	☐			
5. Are you wearing contact lenses?	☐	☐			
6. Do you have a persistent cough or throat clearing not associated with a known illness?	☐	☐			
7. Are you allergic to or have you had any reactions to the following:	☐	☐			
Local Anesthetics (e.g. Novocain)	☐	☐			
Penicillin or any other antibiotics	☐	☐			
Barbiturates	☐	☐			
Sulfa Drugs	☐	☐			
Sedatives	☐	☐			
Aspirin	☐	☐			
Iodine	☐	☐			
Any Metals (nickel, mercury, etc.)	☐	☐			
Latex Rubber	☐	☐	11. Do you need to pre-medicate for any reason? _____		
Acrylic	☐	☐	12. Have you ever taken Fen-Phen/ Redux?	☐	☐
Other _____	☐	☐	13. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
8. May we list the above allergies on the outside of your chart for your safety?	☐	☐	14. Have you taken Viagra, Revatio, Cialis or Levitra in the past 24 hours?	☐	☐

Do you have or have you had any of the following:

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/ Allergies	☐	☐
Fainting/ Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/ Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/ Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/ Ulcers	☐	☐	Other _____	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

✖ _____

Signature of patient (or parent/ guardian if minor) Date