Update Yourself

1 ABOUT YOU

Today's Date: _____

Name: _____
Last First MI Mr Mrs Ms Dr

Home Address: _____

_____
City State Zip

Home Phone #: (_____) _____

Cell #: (_____) _____ Wk #: (_____) _____

E-Mail Address: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

Occupation: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Name: _____

In the event of an emergency, whom should we contact?

His/Her Name: _____ Relation: _____

Ph #: (_____) _____ Cell #: (_____) _____

2 INSURANCE INFORMATION

Has any of your insurance information changed? ☐ No ☐ Yes
If your insurance has not changed, please continue onto block 3.

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

INITIAL

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office). *Please provide any new Primary/Secondary Insurance cards with this form.*

3 MEDICAL INFORMATION

Since your last appointment have there been any changes in your health? If yes, please explain:

_____

_____

1. Is there anything about your teeth, mouth or jaw that concerns you? ☐ Yes ☐ No
   If yes, What? _____
2. Do you have any other concerns about today's appointment that you would like to bring to the doctor's attention? ☐ Yes ☐ No
   If yes, What? _____
3. Are you presently under the care of a physician for any medical reasons? ☐ Yes ☐ No
   If yes, What? _____
   Physician's Name: _____
   Phone #: (_____) _____ Date of last visit: _____
4. Are you currently taking any medications? If yes, What? ☐ Yes ☐ No
   _____
5. Do you have a medical condition (heart murmur, heart defect, etc.) that requires antibiotics before dental treatment? ☐ Yes ☐ No
   If yes, what prescribed medication have you taken? _____
   How much? _____ What time? _____
6. Are you allergic to medicine(s) or other product(s)? ☐ Yes ☐ No
   If yes, What? _____
7. Are you allergic to vinyl, metal or acrylics? ☐ Yes ☐ No
   If yes, What? _____
8. Are you allergic to latex (gloves, rubber products)? ☐ Yes ☐ No
   If yes, What? _____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any further changes to the information I have provided.

Signature: _____

Date: _____