

Established Patient – Yearly Update

To help us serve you better, please fill out this form as thoroughly as possible.

THIS IS YOUR HEALTH WE ARE DEALING WITH, TAKE IT SERIOUSLY!

See our separate *Notice of Privacy Practices* for details on how this information may be used.



Form updated 8/23/2017

ABOUT YOU

Name: _____ Preferred Name: _____ Date of Birth: _____
Last First

SSN: _____ - _____ - _____ Male Female Marital Status: Single Married Other

Home Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

CONTACT INFORMATION

Cell#: _____ Home#: _____ Work#: _____ ext. _____

Email: _____

DENTAL INSURANCE INFORMATION (If you do not have dental insurance, skip to the next section)

Dental Insurance Company: _____ Insurance Co. Phone: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

Policy Holder's SSN: _____ - _____ - _____ Account #: _____ Group #: _____

RECENT ORAL HEALTH HISTORY

In the last several months, have you experienced any of the following:

- Painful teeth or gums Sensitive teeth Bleeding gums Bad Breath Chipped/Broken teeth
 Clenching/Grinding Sore jaw muscles Stained teeth Other: _____

RECENT MEDICAL HISTORY

Are you under a physician's care now? Yes No Please list **any and all** medications, drugs, and supplements you take:

Do you currently smoke or chew tobacco **at all**? Yes No
Women: Are you pregnant or trying? Yes No
Have you been hospitalized or had **any** surgery in the last six months? Yes No (if yes, please describe): _____

Are you allergic to any of the following?
 Aspirin Penicillin/Amoxicillin Latex
 Acrylic Codeine/Hydrocodone Metal
 Sulfa drugs Other: _____

In the last six months, have ever you experienced any of the following?

- | | | | | | | | |
|--------------|--|-------------------|--|-------------------|--|------------------|--|
| Anaphylaxis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treat. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy/Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Press. | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Issues | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excess Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors/Growths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores | <input type="checkbox"/> Yes <input type="checkbox"/> No | Freq. Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please list ANY other recent medical issues: _____

Acknowledgement and Signature

I have completed this questionnaire accurately and completely, and understand that providing false or misleading information can be dangerous to my health. It is my responsibility to inform Inman Park Dentistry of any changes in my medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____ Date: _____