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.

INMAN PARK DENTISTRY
DOCTORS of DENTAL MEDICINE

ABOUT YOU

Form updated 8/23/2017

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 you ever experienced any of the following?

Anaphylaxis	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Heart Attack	❑ Yes ❑ No	Radiation Treat.	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Epilepsy/Seizures	❑ Yes ❑ No	High Blood Press.	❑ Yes ❑ No	Sinus Issues	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Excess Bleeding	❑ Yes ❑ No	Kidney Problems	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Fainting Spells	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Tumors/Growths	❑ Yes ❑ No
Cold Sores	❑ Yes ❑ No	Freq. Headaches	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No	Ulcers	❑ Yes ❑ 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: _____