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: ______________

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