

# UPDATED PATIENT INFORMATION FORM

*Please provide receptionist with your driver's license and insurance card so a photo copy can be made for our records*

S.S # \_\_\_\_\_

Date \_\_\_\_\_

Name \_\_\_\_\_ Birthday \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F  Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years

E-mail \_\_\_\_\_ Cell Phone #1 (\_\_\_\_) \_\_\_\_\_ Cell Phone #2 (\_\_\_\_) \_\_\_\_\_

Employer/School \_\_\_\_\_ Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Employer/School Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Have you had any serious illnesses or operations?  Yes  No If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

List medications you are currently taking and the correlating diagnosis: \_\_\_\_\_ Allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

*Payment is due in full at time of treatment*