ANNUAL PATIENT INFORMATION UPDATE

To keep our records current, please complete the following. PLEASE PRINT

Date:_____

Name:_____ E-mail_____

Address:_____ City, State, Zip:_____

Home Phone:_____ _ Cell Phone:_____ Work Phone:_____

How would you prefer confirmation of appointments? E-mail____ Home Phone____Work____Cell____

Person to contact on case of emergency:_____ Phone: _____

Has there been a change in your Dental Insurance since your last visit? Yes: _____ No: _____
If so please complete the following and allow us to make a copy of your new insurance card.

Name of Insured:_____ Relationship to Patient:_____

Birth Date: _____ SS#: _____ Employer:_____

Address of Employer:_____ City, State, Zip:_____

Insurance Company:_____ Group#:_____ Policy/ID#:_____

Please list any medical changes in the past year:_____

Have you been hospitalized in the last 3 years:_____ Reason:_____

Please list all current medications:_____

Please list all allergies to medications:_____

Do you need to pre-medicate with an antibiotic for dental treatment:_____
If yes, please list which one:_____

Do you take any medication for osteoporosis?_____ If yes, please list which one____

Name and phone number of preferred pharmacy:_____

Do you have any concerns you would like to discuss at today's appointment?:_____

Patient's Signature:_____