ANNUAL UPDATE FORM FOR CURRENT PATIENTS

EMAIL:	CELL PHONE:

Patient Name: _____ Preferred Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Age: _____ DOB: _____

S.S. # _____ Driver's License: _____ ❑ Single ❑ Married ❑ Divorced

❑ Widowed ❑ Separated ❑ Minor .

Employer's Name: _____ Occupation: _____

Did your Dental Insurance Changed? Yes _____ No _____ if yes, explain: _____

PARENT/GUARDAIN INFORMATION (IF PATIENT IS A MINOR)

Name: _____ Relationship to the patient: _____

Birth Date: _____ SS#: _____ Driver's License: _____

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

Home Phone#: _____ Cell Phone: _____ Email Address: _____

DENTAL HISTORY

Do you like your smile? Yes _____ No_____ what, if anything, would you change about your smile?

_____

Reason for today's visit: _____

Are you interested on Teeth Whitening? Yes____ No ____ Are any of your teeth moving? Yes ____ No ____

Are you currently in pain? Yes _____ No_____

Do you now have or have you ever experienced pain or discomfort in your jaw (TMJ)? Yes _____ No _____

Check if you have had any of the following: (Mark yes or no)

Yes ❑ No ❑ Bad Breath Yes ❑ No ❑ Food collection between teeth Yes ❑ No ❑ Sensitivity to heat

Yes ❑ No ❑ Bleeding gums Yes ❑ No ❑ Loose teeth /broken fillings Yes ❑ No ❑ Sensitivity to sweets

Yes ❑ No ❑ Clicking or popping jaw Yes ❑ No ❑ Periodontal treatment Yes ❑ No ❑ Sensitivity when biting

Yes ❑ No ❑ Sores in your mouth Yes ❑ No ❑ Sensitivity to cold Yes ❑ No ❑ Grinding teeth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Do you have a Primary Care Physician? ❑ Yes ❑ No Physician Name: _____

Phone Number: _____ Date of last visit: _____

Have you ever had any serious illness or operation? ❑ Yes ❑ No Describe _____

Have you ever been hospitalized? ❑ Yes ❑ No Describe _____

Do you have any metal rods, pins or implants? ☐ Yes ☐ No Describe _____

Have u ever taken Phen –Fen? ☐ Yes ☐ No

Have you ever taken Fosamax or any other Bisphosphanate? ☐ Yes ☐ No If so when? _____

Are you taking any prescription/drugs/over the counter drugs? ☐ Yes ☐ No if yes, please list each one:

_____

(Women) Are you pregnant? ☐ Yes ☐ No if so, how many months ____ Are you Nursing ☐ Yes ☐ No

ARE YOU SENSITIVE OR ALLERGIC TO THE FOLLOWING MEDICATIONS?

Yes ☐ No ☐ Penicillin Yes ☐ No ☐ Tetracycline Yes ☐ No ☐ Erythromycin Yes ☐ No ☐ Asprin

Yes ☐ No ☐ Codine Yes ☐ No ☐ Sulfa Drugs Yes ☐ No ☐ Latex Yes ☐ No ☐ Dental Anesthetics

If other, what medications? _____

Do you have a disease, condition or problem not listed that you think I should know about? _____

_____

CHECK IF YOU HAVE / HAD ANY OF THE FOLLOWING: (Mark your answers)

Yes ☐ No ☐ Aids	Yes ☐ No ☐ Epilepsy	Yes ☐ No ☐ Liver Disease
Yes ☐ No ☐ Anemia	Yes ☐ No ☐ Fainting	Yes ☐ No ☐ Mitral Valve
Yes ☐ No ☐ Arthritis, Rheumatism	Yes ☐ No ☐ Glaucoma	Yes ☐ No ☐ Pacemaker
Yes ☐ No ☐ Artificial Heart Valves	Yes ☐ No ☐ Heart Attack	Yes ☐ No ☐ Psychiatric Care
Yes ☐ No ☐ Artificial Joints (Bones)	Yes ☐ No ☐ Headaches	Yes ☐ No ☐ Rheumatic fever
Yes ☐ No ☐ Asthma	Yes ☐ No ☐ Herpes/Fever Blisters	Yes ☐ No ☐ Sinus Problems
Yes ☐ No ☐ Cancer/Chemotherapy	Yes ☐No ☐ Hemophilia	Yes ☐ No ☐ Stroke
Yes ☐ No ☐ Chemical Dependency	Yes ☐ No ☐ Heart Murmur	Yes ☐ No ☐ Swelling of Feet
Yes ☐ No ☐ Circulatory Problems	Yes ☐ No ☐ HIV Positive	Yes ☐ No ☐ Scarlet Fever
Yes ☐ No ☐ Congenital Heart Disease	Yes ☐ No ☐ High Blood pressure	Yes ☐ No ☐ Seizures
Yes ☐ No ☐ Cortisone Treatments	Yes ☐ No ☐ Hepatitis	Yes ☐ No ☐ Thyroid Problems
Yes ☐ No ☐ Cough, Persistent	Yes ☐ No ☐ Jaw Pain	Yes ☐ No ☐ Tuberculosis
Yes ☐ No ☐ Diabetes	Yes ☐No ☐ Kidney Disease	Yes ☐ No ☐ Tobacco Habit
Yes ☐ No ☐ Difficulty Breathing	Yes ☐ No ☐ Lupus	Yes ☐ No ☐ Venereal Disease

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____ _____

Date Patient Signature

Parent/Guardian Signature **if Patient is a minor:** _____ **Date:** _____

Dentist signature: _____ **Date:** _____