Annual Update

Please fill out the following form in completion to help us provide you with the best care possible! Thank you.

Personal Information

Today's Date: ________________

Email Address: ______________________________________

Patient Name: _____________________________________

Address: ____ Apt/Condo #

____
City State Zip Code

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Best Number to reach you: (______)______________________

In Case of an Emergency who should we contact?

____________________________ (____)_____-_________

Relationship to Patient: _________________________________

Insurance

Any changes to your insurance since your last visit? ☐Yes ☐No

If yes please complete the following and ***provide the front office with a copy of your new card:***

Insurance Co. Name: __________________________________

Insurance Co. Phone #: (_______)___________________

Insured's Name: ________________ Relation:________________

Insured's Birthdate: ____/____/____ ID#: _____-____-______

Do you have a *secondary insurance* that is not on file with us?

☐Yes ☐No *If **Yes** please provide us with a copy of your card.*

Current Physician

Physician's Name:

____

City: __________________ State: ______ ZipCode: ________

Phone #: (____)_____________ Date of last visit: _____________

Specialty: __________________

Are you currently under the care of a physician? ☐Yes ☐No

Please Explain: ______________________________________

____

____

Allergies

Are you **allergic** to any of the following?

Y N Erythromycin Y N Codeine Y N Latex
Y N Dental Anesthetics Y N Penicillin Y N Other

Please List Any other Allergies:

____

____

____

____

Medical Changes

Have there been any changes in your overall health in the past 12 months including any *surgeries or hospitalization*? ☐Yes ☐No
If yes please explain:

____

____

____

Are you currently taking any prescription drugs or non-prescription drugs? ☐Yes ☐No
Please List All:

_______________ _______________ _______________

_______________ _______________ _______________

_______________ _______________ _______________

_______________ _______________ _______________

Do you use tobacco in any form (eg: smoking/chewing/vaping)?
☐Yes ☐No

Women Only:
Are you pregnant? ☐Yes ☐No
Are you nursing? ☐Yes ☐No

*I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

____
Signature of Patient/Parent/Guardian

Date: _____________ Relationship to Patient: __________________