UPDATE

1 PERSONAL INFO

Today's Date: ____/____/____ D.O.B: ____

Patients Name: ____ (LAST) (FIRST) (MI)

SS# ____

Mailing Address: ____ ☐ UNCHANGED

(CITY) (STATE) (ZIP)

Home Phone #:(____) ____

(____) ____ (____) ____

(OFFICE PHONE) (EXT.) (CELL PHONE)

E-mail Address: ____

Employer / School: ____ ☐ FULL TIME STUDENT

Employer's/School's Address: ____

(CITY) (STATE) (ZIP)

Occupation: ____

Marital Status: ____ ☐ UNCHANGED

Spouse's Name: ____

2 INSURANCE INFO

Has any of your Insurance Information changed? ☐ No ☐ Yes

If your Insurance info has not changed, please continue on to section 3

Ins. Co. Name: ____

Address: ____

(CITY) (STATE) (ZIP)

Phone #: (____) ____

Insured's ID # or SS#: ____

Group # (Plan, Local or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

____ (Initials) 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 Ins. Cards with this form.

3 MEDICAL HISTORY

Physician ____ Office Phone ____ Date of Last Exam ____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain. ____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ____		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any other Medications containing bisphosphonates?	☐	☐
6. Do you use tobacco?	☐	☐
7. Do you use controlled substances?	☐	☐
8. Are you wearing contact lenses?	☐	☐

10. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) ____	☐	☐

11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) ☐ ☐

12. Women Only:

a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other ____	☐	☐

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: ____/____/____