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ANNUAL UPDATE FORM

PLEASE COMPLETE THIS PATIENT UPDATE FORM, WE'RE GLAD YOU'RE HERE AGAIN!

Patient Information

Full Name: ____________________
Preferred Name: ____________________
Address:
____
____
DOB: ____________________

Email Address: ____________________
Marital Status: S M D W
Spouse Name: ____________________

Home # __________ Cell # __________
Work # __________ Other # __________

In Event of Emergency

Whom should we contact:
____
Relation:
____

Home # __________ Cell # __________

Who is your Medical Doctor:
____
Medical Doctor's Phone #
____

Medical History Update

1. Have there been any changes in your health since your last dental appointment ………………….. ❑ YES ❑ NO
   If yes, for what conditions ____________________
2. Are you taking any Medications at this time ………...……………. .❑ YES ❑ NO
   If yes, please list them ____________________
3. Do you have any Allergies, or adverse reactions to any medications ………........……………... ❑ YES ❑ NO
   If yes, please explain ____________________
4. *Women*, Are you currently pregnant ……………………………………...…………………. ❑ YES ❑ NO
   If yes, when is your due date ____________________
5. Do you have any other Health, Medication, or Allergy Conditions that are not listed above. ……. ❑ YES ❑ NO
   If yes, please explain ____________________
6. Please provide your pharmacy information: ____________________

GUARANTEE OF ACCOUNT

I guarantee full payment of all dental charges incurred by the above patient. I give my consent to needed dental services recommended for my (or any dependents) benefit and accept full responsibility of payment for services performed. I understand the above information and affirm this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information that I have provided.

Patient/Guardian signature ____________________ *Date* ____________________