Update for Existing Patients

Section 1: Patient Information

Patient Name: _____ I prefer to be called: _____
Address: _____ City: _____ St: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____
The best way to contact me is on my: ▢ Home Phone ▢ Work Phone ▢ Cell Phone ▢ Text ▢ Email
Birth date: _____ Patient SSN: _____ Driver's License #: _____
Check appropriate box: ▢ Male ▢ Female ▢ Child ▢ Single ▢ Married ▢ Widowed ▢ Separated ▢ Divorced
If student, name of school: _____
How did you hear about our office? _____

Employer

Patient's Employer: _____
Employer Address: _____ City: _____ St: _____ Zip: _____

Spouse

Spouse's Name: _____
Birth date: _____ SSN: _____ Driver's License #: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____

Emergency Contact

Person to contact in case of emergency: _____ Relationship to patient: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Section 2: Parent/Guardian Information (if patient is a child)

Parent/Guardian 1: _____
Relationship: ▢ Mother ▢ Stepmother ▢ Father ▢ Stepfather ▢ Guardian
Address: _____ City: _____ St: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____
The best way to contact me is on my: ▢ Home Phone ▢ Work Phone ▢ Cell Phone ▢ Text ▢ Email
Birth date: _____ Patient SSN: _____ Driver's License #: _____
Check the appropriate box: ▢ Single ▢ Married ▢ Widowed ▢ Separated ▢ Divorced

Parent/Guardian 2: _____

Relationship: ▢ Mother ▢ Stepmother ▢ Father ▢ Stepfather ▢ Guardian

Address: _____ City: _____ St: _____ Zip: _____

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

Email Address: _____

The best way to contact me is on my: ▢ Home Phone ▢ Work Phone ▢ Cell Phone ▢ Text ▢ Email

Birth date: _____ Patient SSN: _____ Driver's License #: _____

Check the appropriate box: ▢ Single ▢ Married ▢ Widowed ▢ Separated ▢ Divorced

Section 3: Person Responsible for Account

Name: _____ Relationship to patient: _____

Billing Address: _____ City: _____ St: _____ Zip: _____

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

Email Address: _____

The best way to contact me is on my: ▢ Home Phone ▢ Work Phone ▢ Cell Phone ▢ Text ▢ Email

Birth date: _____ Patient SSN: _____ Driver's License #: _____

Section 4: Insurance Information

Name of Insured: _____ Birth date: _____

Relationship to patient: _____ Insured SSN: _____

Name of employer: _____ Work Phone: _____

Work Address: _____ City: _____ St: _____ Zip: _____

Insurance Company: _____ Group No: _____ ID No: _____

Ins. Co. Address: _____ City: _____ St: _____ Zip: _____

Ins. Co. Phone: _____

Do you have any additional insurance? ▢ Yes ▢ No If yes, complete the following.

Name of Insured: _____ Birth date: _____

Relationship to patient: _____ Insured SSN: _____

Name of employer: _____ Work Phone: _____

Work Address: _____ City: _____ St: _____ Zip: _____

Insurance Company: _____ Group No: _____ ID No: _____

Ins. Co. Address: _____ City: _____ St: _____ Zip: _____

Ins. Co. Phone: _____

Medical History

Do you have a personal physician? ▢ Yes ▢ No Date of last visit?_____

Physician's name: _____ Main Phone: _____

Address: _____ City: _____ St: _____ Zip: _____

Are you currently under the care of a physician? ▢ Yes ▢ No If yes, please explain:_____

Your current physical health is: ▢ Good ▢ Fair ▢ Poor

Please list any medications you are currently taking:

_____

_____

_____

Do you use tobacco in any form? ▢ Yes ▢ No

Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphosphonate? ▢ Yes ▢ No

Have you ever taken Phen-Fen? ▢ Yes ▢ No

For women:

Are you taking birth control? ▢ Yes ▢ No

Are you pregnant? ▢ Unsure ▢ Yes ▢ No Week #: _____ Are you nursing? ▢ Yes ▢ No

Have you ever had any of the following disease or medical problems? Please check appropriate box.

- ▢ ADD/ADHD
- ▢ AIDS or HIV infection
- ▢ Anemia
- ▢ Arthritis
- ▢ Artificial Bones/Joints/Valves
- ▢ Asthma
- ▢ Cancer
- ▢ Congenital Heart Defect
- ▢ Diabetes
- ▢ Drug/Alcohol Abuse
- ▢ Emphysema
- ▢ Epilepsy/Convulsions
- ▢ Fainting/Seizures
- ▢ Fever Blister/Herpes
- ▢ Frequently Tired
- ▢ Glaucoma
- ▢ Handicaps/Disabilities
- ▢ Hearing Impairment
- ▢ Heart Attack
- ▢ Heart Murmur
- ▢ Heart Surgery/Pacemaker
- ▢ Hemophilia/Abnormal Bleeding
- ▢ Hepatitis/Jaundice
- ▢ High Blood Pressure
- ▢ Kidney Diseases
- ▢ Liver Disease
- ▢ Low Blood Pressure
- ▢ Mitral Valve Prolapse
- ▢ Psychiatric Problem
- ▢ Radiation Therapy
- ▢ Respiratory Problems
- ▢ Rheumatic/Scarlet Fever
- ▢ Shingles
- ▢ Sickle Cell Disease/Traits
- ▢ Stomach Troubles/Ulcers
- ▢ Stroke
- ▢ Thyroid Problem
- ▢ Tuberculosis
- ▢ Other: _____

Please list any other serious medical condition(s) that you have ever had: _____

_____

Are you allergic to any of the following? Please check appropriate box.

- ▢ Aspirin
- ▢ Tetracycline
- ▢ Sulfur Drugs
- ▢ Erythromycin
- ▢ Latex
- ▢ Iodine
- ▢ Penicillin
- ▢ Jewelry/Metals
- ▢ Plastic
- ▢ Codeine
- ▢ Dental Anesthetics
- ▢ Other: _____

Please list any other drugs/materials you are allergic to: _____

_____