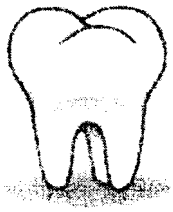
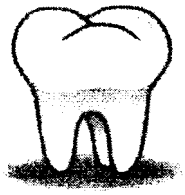


Existing Patient Update Form



Please complete this Patient Update and return it to the Front Desk.
We're glad you're here again!

Patient Information

Full Name: _____
Preferred Name: _____
Address: _____
_____
DOB: _____

Marital Status (please circle) S M D W
Spouse Name: _____

*Home #*_____ *Cell #*_____
*Work #*_____ *Other #*_____
*Email Address*_____

In Event of Emergency

Whom should we contact _____
*Relation*_____
*Home #*_____ *Cell #*_____

Who is your Medical Doctor _____
Medical Doctor's Phone #

Account Information

Please indicate your Payment Method for Services;
_____ *Fee for Service (Cash, Check, Charge)*
_____ *Private Insurance*
_____ *Medicaid*
Please notify our receptionist if your insurance carrier has changed.

Medical History Update

1. Have there been any changes in your health since your last dental appointment.....YES NO
   a. If yes, for what conditions_____
2. Are you taking any medications at this time.....YES NO
   a. If yes, please list them_____
3. Do you have any allergies or adverse reactions to any medications.....YES NO
   a. If yes, please explain_____
4. *Women,* Are you currently pregnant.....YES NO
   a. If yes, when is your due date _____
5. Is there anything we need to know about your health that is not listed above.....YES NO
   a. If yes, please list_____

Even if there has been NO change in your health history, please sign & date this form to be made part of your chart.

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 (my minor) benefit and accept full responsibility of payment for services performed. I understand the above information and guarantee 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.

Signed: _____ *Date:*_____
(Guardian must sign, if Patient under 18 years)