Yearly Updated Information Form

Patient Name ____
Last First MI Date of Birth

Phone (Home): _________________**(Work):**_______________**(Cell):**_________________

Email:______________________ **SSN:**________________ **Driver's License#:**________________

Address: ____
Street Apartment #

____
City State Zip Code

Dental Insurance: Primary____________________ **Secondary**______________________

YES □ **NO** □ Have there been any changes in your medical since your last visit to our office? If yes, please describe?____

YES □ **NO** □ Have you been ill or hospitalized since your last visit? If yes, please describe: ____

YES □ **NO** □ Have you been under the care of a physician since your last visit to this office? If yes, Please describe:____

YES □ **NO** □ (Woman) Are you pregnant? If yes, Congratulations! How many weeks are you?_______

If you have or have had any of the following:

□Autoimmune Disease	□Chronic Sinus	□Heart Problems	□Respiratory Disease
□AIDS	□Circulatory Problems	□Hemophilia	□Rheumatic Fever
□Anxiety	□Cortisone Treatment	□High Blood Pressure	□Shortness of Breath
□Anemia	□Cold Sore/Herpes	□HIV Positive	□Sleep Apnea
□Artificial Heart Valves	□Dental Phobia	□Jaw Pain	□Snoring
□Artificial Joints	□Depression	□Kidney Disease	□Stroke
□Asthma	□Diabetes Type___	□Liver Disease	□Tension Headache
□Blood Disease	□Epilepsy	□Mitral Valve Prolapse	□Thyroid Problems
□Cancer__________	□Excessive Bleeding	□Migraine	□TMD Problems
□Osteoporosis	□Facial Pain	□Neurological Issues	□Tobacco Habit
□Chemical Dependency	□Fainting	□Pacemaker	□Tuberculosis
□Chemotherapy	□Head Injury	□Psychiatric Care	□Ulcers
□CPAP Therapy	□Heart Murmur	□Radiation Treatment	

Medications List below all medications you are taking:
____
____
____

Allergies List below all allergies you have:
____
____
____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

____ Date:_____________
Signature of patient, parent or guardian