PATIENT INFORMATION UPDATE
124 Timber Drive
Dayton, TN 37321

Medical Alert for Office Use

Patient Information

Thank you for visiting Today's Dental. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Name: ________________________________ Preferred Name: ______________________

Address:____

City: ___________________________ State: ________ Zip: ______________

Phone: Home (   ) ____________________ Work (   )_________________________

Cell Phone: (   )________________________ Employer: ____________________________

E-MAIL____

Emergency Contact: Name _________________________ Phone:_________________

Relation to the Patient: ___________________________

If there is anyone who might call to inquire about your healthcare or payments and you do **NOT** wish we share this information with them, please list their name and relationship to you.

Name_____________________________ Relationship ____________________________

Has your Insurance information changed?

Primary Insurance carrier**:** ____

Policy Holder: ____

Id Number:____________________________ Group Number: _____________________

Insurance Phone Number: ____

Drug Allergies: Please circle NONE if you do not have any allergies. None

- ❑ Aspirin
- ❑ Latex
- ❑ Barbiturate
- ❑ Codeine
- ❑ Penicillin
- ❑ Sulfa
- ❑ **Other** _____________________________

Do you have or have you ever had? Yes or No

- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ Other
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaundice
- ❑ Kidney Problems
- ❑ Low Blood Pressure
- ❑ Rheumatic Fever
- ❑ Sexually Transmitted Diseases
- ❑ Stroke
- ❑ Tuberculosis

Are you currently under the care of a physician? Yes ❑ or No ❑

Please explain:

Have you seen a physician within the last 12 months? Yes or No

If so, who was your Dr.? ___________________________________

Please explain why you saw him:

Please list any medication you are currently taking: (Including Bone Densitiy Medications, Baby Asprin, or Blood thinners)

Female Patients: Are you pregnant? Yes ❑ or No ❑ If yes, when is your due date? ___________

Have you had any new surgeries or have you been hospitalized since your last visit?

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor patient and/or parent or Guardian to be necessary or advisable including the use of local anesthesia and other medications as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

Signature Date

If patient is a child or requires a guardian:

____Parent/Guardian signature Date