Please Update Your Information for Wawasee Family Dentistry

Patient Information:

Date:_____Name:_____

Birthday:_____ Social Security # :_____

Phones: Home:_____ Cell:_____

Address:_____ City:_____ Zip:_____

Emergency Contact :_____

Relationship: _____ Phone: _____

Primary Insurance:

Policy Holder's Information:

Name:_____ Social Security #:_____

Birthday:_____ Relationship to Patient:_____

Employer:_____ Insurance Company:_____

Group#:_____ Contact Number:_____

Who is responsible for this Bill?

I will be paying for my portion today by : Cash Check Credit/Debit Card

I understand and agree that I am ultimately responsible for the balance of this account for any professional services rendered. I have read all the information on both forms and completed the answers to the best of my knowledge. I will notify you of any changes in my status on the information given.

Signature:_____ **Date:**_____

SEE BACK

Medical History

Family Physician _____ Last Date Visited _____

Have you ever had any serious illness/operations? Yes No

If Yes, explain what and when _____

Are you Pregnant? Yes No Currently Breast Feeding? Yes No On Birth Control? Yes No

Please Check any of the following that have occurred:

__Anemia	__Cancer	__Diabetes
__High Blood Pressure	__Radiation Treatment	__ FeetAnkle Swell
__Arthritis, Rheumatism	__Chemical Dependency	__Glaucoma
__HIV/AIDS	__Respiratory Disease	__Thyroid Problem
__Artificial Heart Valves	__Chemotherapy	__Headaches
__Jaw Pain	__Rheumatic Fever	__Tobacco Habit
__Artificial Joints	__Circulatory Problem	__Heart Murmur
__Kidney Disease	__Scarlet Fever	__Tonsillitis
__Asthma	__Cortisone Treatment	__Heart Problems
__Liver Disease	__Shortness of Breath	__Tuberculosis
__Back Problems	__Persistent Cough	__Hemophilia
__Mitral Valve Prolepses	__Skin Rash	__Ulcer
__Blood Disease	__Coughing up Blood	__Hepatitis
__Pacemaker	__Stroke	__Venereal Disease
__Seizure	__ Autisim/Sensory	__ ADD/ADHD

Any other mental or physical Impairments?_____

Current Medications: ****Allergic To:****

_____ _____

_____ _____

_____ _____

Do you require antibiotics before dental treatment? Yes No (mainly if you've had a joint replacement, implant, or a heart condition requiring it.)To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child ever have a change in health.

Signature_____Date_____