Panther Hollow Dental Lodge, PL

Established Patient Information Update

Patient Information

Patient Name:____ Date:__________________

Last First M. (preferred name)

Home Address:______________________________ E-mail:______________________________

____

Phone (Home):______________ (Work):______________ Ext:________ (Cell):______________

Employment / Insurance <u>(If any changes since last visit)</u>

Patient Employer Name ____________________________

Insurance Co. Name:____

Claim Mailing Address:________________________ Subscriber Name: ____________________

____________________________________ Relation to Patient: ____________________

Insurance Co. Phone#:________________________ Subscriber Birthdate: ____________________

Group Plan Name: __________________________ Subscriber SS#: ____________________

Group/ Policy#: __________________________ Subscriber ID#: ____________________

Medical Information <u>(Please Answer All Questions)</u>

1. Do you have any Major / General Health problems at the time? Yes / No
   If so, please specify: ____
2. Are you presently under a physician's care? Yes / No
   If so, for what reason? ____
3. Have you been hospitalized within the last two years? Yes / No
   If so, for what reason? ____
4. To the best of your knowledge, do you have or have you ever had: ***<u>(Circle Y / N)</u>***

Heart Conditions Yes / No
If so, please specify:________________________

Cancer / Tumor Yes / No

High / Low Blood Pressure Yes / No

Hepatitis Yes / No

Diabetes Yes / No

Artificial Joint Replacement Yes / No
If so, please specify:________________________

Respiratory Diseases Yes / No
If so, please specify: ________________________

Dementia / Alzheimer Yes / No

Stroke Yes / No

Osteoporosis Yes / No

5. Is there anything else we should know regarding your health since your last visit? Yes / No ______________
   ____
6. Are you taking any blood thinners / aspirin? Yes / No
7. Is Antibiotic Pre-Medication required prior to dental treatment? Yes / No
8. Are you allergic to any local anesthetics, drugs or medications? Yes / No
   If so, please specify: ____
9. Are you currently taking any drugs or medications? Yes / No
   Please list medications: ____
   ____

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 doctors at the next appointment without fail.

________________________ Date:____________________ Relationship to Patient:____________

Signature of patient, parent or guardian