Update

Todd A. Carter, D.D.S., Inc.

Date _____

Home Phone # _____

Cell Phone # _____

Driver's License or
Social Security # _____

Patient Information (CONFIDENTIAL)

Name _____ Nickname: _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Boxes: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Male ☐ Female

Employer/School _____ Contact # _____

Spouse or Parent's Name _____ Contact # _____

Name of Person Responsible for this Account _____ D.O.B. _____

Emergency Contact (Relationship) _____ Contact # _____

Insurance Information ☐ Same ☐ New

Name of Insured _____ Relationship to Patient _____ Birthdate _____

Name of Employer _____

Insurance Company _____ Policy/ID # _____ Group # _____

Patient Medical History

Physician _____ Office # _____ Date of Last Exam _____

Name _____ Date _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If Yes, please describe _____

_____

Does your physician require you to take special medication(s) before dentistry? If so, what? _____

Are you now or have you ever taken drugs for Osteoporosis? ☐ Yes ☐ No If yes, for how long? _____

Do you take a blood thinner? ☐ Yes ☐ No Are you under any medical treatment now? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No If yes, what type? _____ How Often? _____

Check (✔) if you have or have had in the past any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
  Location: _____
- ☐ Asthma
- ☐ Autism
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
  Type: _____
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes Type: _____
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hayfever/Allergies
- ☐ Headaches
- ☐ Hearing Aids
- ☐ Heart Murmur
- ☐ Heart Problems (describe)
  _____
  _____
- ☐ Hemophilia
- ☐ Hepatitis Type: _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pace Maker
- ☐ Parkinson's
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sexually Transmitted Disease
- ☐ Shortness of Breath/COPD
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet/Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Vertigo
- ☐ Yellow Jaundice
- ☐ Other: _____
  _____

Women:
Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control? ☐ Yes ☐ No

Medications

List any medications you are currently taking:

*Or we would gladly copy a list

_____

_____

_____

_____

_____

_____

_____

Allergies ☐ None

Check (✔) if you are allergic to or have had any reactions to the following:

☐ Local Anesthetics (eg. Novocaine)

☐ Penicillin (or other Antibiotic - List Separately)

_____

☐ Sulfa Drugs ☐ Latex Rubber

☐ Barbiturates ☐ Sedatives

☐ Iodine ☐ Aspirin ☐ Codeine

☐ Any Metals (eg. Nickel, Mercury, etc.)

Other: _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

x _____

Signature of patient (parent if minor) Date

Medical History Update

Patient:

The patient information and medical history have been reviewed. The patient information, health status and medication has changed as follows. (If no changes, write "no changes".)

Health Changes: _____

_____

Present Medications: _____

_____

Patient / Parent / Guardian (circle one)

Siganture: _____

Date _____ Reviewed By: _____

Health Changes: _____

_____

Present Medications: _____

_____

Patient / Parent / Guardian (circle one)

Siganture: _____

Date _____ Reviewed By: _____

Health Changes: _____

_____

Present Medications: _____

_____

Patient / Parent / Guardian (circle one)

Siganture: _____

Date _____ Reviewed By: _____

Health Changes: _____

_____

Present Medications: _____

_____

Patient / Parent / Guardian (circle one)

Siganture: _____

Date _____ Reviewed By: _____