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Demographic & Medical History Update

Name: ☐ Name Change DOB:

☐ Change of Address, Phone, Status or insurance ☐ No Change Primary Care Physician:

New address:

New Phone Number: ( )

Change in Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Dentist:

INSURANCE INFORMATION & MEDICAL HISTORY UPDATE FORM

PRIMARY INSURANCE INFORMATION ■ New ■ Additional ■ Change of Information

DO YOU HAVE MEDICAL COVERAGE? ☐Yes ☐No

PRIMARY MEDICAL

Name of insured:
Date of birth:
Relationship to patient:
Insured's employer:
Insurance company name:
Insurance ID#:
Group number:
Insurance address:
City: State: Zip:
Insurance phone#:
If Union, Local#:

DO YOU HAVE DENTAL BENEFITS? ☐Yes ☐No

PRIMARY DENTAL BENEFIT

Name of insured:
Date of birth:
Relationship to patient:
Insured's employer:
Insurance company name:
Insurance ID#:
Group number:
Insurance address:
City: State: Zip:
Insurance phone#:
If Union, Local#:

SECONDARY INSURANCE INFORMATION ■ New ■ Additional ■ Change of Information

SECONDARY MEDICAL

Name of insured:
Date of birth:
Relationship to patient:
Insured's employer:
Insurance company name:
Insurance ID#:
Group number:
Insurance address:
City: State: Zip:
Insurance phone#:
If Union, Local#:

SECONDARY DENTAL BENE

Name of insured:
Date of birth:
Relationship to patient:
Insured's employer:
Insurance company name:
Insurance ID#:
Group number:
Insurance address:
City: State: Zip:
Insurance phone#:
If Union, Local#:

YES NO PLEASE UPDATE PATIENT HEALTH HISTORY

☐ ☐ **Are there any recent changes in your medical condition or overall health?** If yes, please explain:

☐ ☐ **Have you had any recent surgeries?** If yes, please explain:

Have you had any recent traumas? If yes, please explain:

☐ ☐ **Are you currenty taking any medication?** If yes, please list medications:

Name	*Dose*	*Frequency*

☐ ☐ **Do you have any new allergies since your last visit?** If yes, please list allergies:

Type	*Reaction (rash/hives/airway)*	*Duration*

☐ ☐ **Do you suffer from any chronic illnesses such as:** ☐ Asthma ☐ Diabetes ☐ Thyroid Disease
If yes, please explain: ☐ Heart Disease ☐ Other:

Patient Signature: Date: Witness: Doctor: