RADIANT DENTAL

PATIENT UPDATE FORM

Last Name: _____ **First:** _____ **M.I.:** _____ **Date of Birth:** _____

Address:
New Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number/Email:
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address:_____

Change in Insurance: **[ ] Yes** **[ ] No**
New Name of Insurance: _____ Primary Subscriber Name: _____

Subscriber Social Security Number: _____ Subscriber Date of Birth: _____

Medical History Update:

Do you have any medical conditions that are currently being treated or have been treated in the past? **[ ] Yes [ ] No**

If **Yes**, please specify: _____

Have there been any changes in your medical history since your last dental visit? **[ ] Yes [ ] No**

If **Yes**, please specify: _____

Have you been ill, hospitalized, or had surgery since the last dental visit? **[ ] Yes [ ] No**

If **Yes**, please specify: _____

Are you currently on any medications? **[ ] Yes [ ] No**

If **Yes**, please list medications and purpose: _____

Are you allergic to any medications / Substances? **[ ] Yes [ ] No**

If **Yes**, please Circle or list: **Penicillin** **Codeine** **Latex** **Local Anesthetics** **Other:** _____

Are you currently seeing a physician? **[ ] Yes [ ] No**

If **Yes**, what is the condition being treat? _____

For *FEMALE ONLY*, are you pregnant? **[ ] Yes [ ] No**

If **Yes**, what month? _____ Due Date: _____

Are You taking Birth Control? **[ ] Yes [ ] No**

Are you Nursing? **[ ] Yes [ ] No**

Note if you are a woman some antibiotics may alter the effectiveness of birth control pills, please consult your Ob/Gyn

Physician's Name: _____ Phone Number: _____

_____ _____
PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE **DATE**

DOCTOR _____ **DATE** _____