PATIENT UPDATE FORM

Mr. □ Mrs. □ Ms. □ Miss. □ Child □

Name_____ Birthdate:_____ Home Phone:_____
(FIRST) (LAST) (DD/MM/YYYY)

Cell Phone:_____ E-mail:_____

Address:_____ City:_____ Postal Code:_____

Sex: Male □ Female □ Care Card # _____

Would you like appointment reminders sent to your phone by text or email?_____

Physician's Name:_____ Phone Number:_____

Specialist Name:_____ Phone Number:_____

Have you had any serious illnesses/ operations?_____ If yes, describe:_____

Have you ever been told if you require medication before dental appointments?_____

Are you allergic to penicillin?_____

Women Only – Are you pregnant or nursing?_____

List medication you are currently taking:

_____
_____
_____
_____
_____

Allergies:

_____
_____
_____
_____
_____

Check (✓) if you have or have had any of the following:

- □ Rheumatic Fever
- □ Heart murmur
- □ Congenital heart condition
- □ Heart attack
- □ Heart surgery
- □ Pacemaker/artificial valves
- □ Angina
- □ Stroke
- □ High blood pressure
- □ Lung/breathing problems
- □ Tuberculosis (TB)
- □ Kidney problem
- □ Liver disease
- □ Hepatitis/Jaundice
- □ AIDS
- □ HIV positive
- □ Venereal disease
- □ Diabetes
- □ Hemophilia
- □ Anemia
- □ Cancer
- □ Psychiatric care
- □ Epilepsy
- □ Thyroid disease
- □ Cortisone/steroid therapy
- □ Asthma
- □ Stomach ulcer
- □ Joint replacement

AUTHORIZATION AND RELEASE

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.

I also understand it is my responsibility to inform the office of any changes to my contact information or any changes in my dental insurance. It has been explained to me that although the staff at 21ST Century Dental Centre will bill my insurance company directly when possible, any balances not paid by my insurance are my responsibility.

I also consent to my personal physician being contacted if necessary.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient