ANNUAL UPDATE

Today's Date _______________ Patient's Name________________________________ Date of birth___________________

Any changes to address or phone number? (If yes, please update) ____

Any changes to your **dental insurance**? (If yes, please update & give card to front desk to be scanned)

Name of Primary Insured____________________________ Their date of birth_____________ Relation to patient___________

Social Security #________________ Insurance company________________________ Employer_________________________

Subscriber ID #_____________________ Group #__________________Insurance phone #____________________________

Health History

Name of your PCP_________________________ PCP Phone #__________________ Date of last visit___________________

Pharmacy Name__________________________ Pharmacy Phone #____________________

List any medications you are currently taking____

____

(Women) Are you pregnant? Yes ☐ No☐ If yes, which trimester?_______________

Check box if you have had problems with any of the following:

- ☐Anemia,
- ☐Arthritis, Rheumatism
- ☐Artificial heart valves
- ☐Artificial joints
- ☐Asthma
- ☐Back problems
- ☐Cancer
- ☐Chemical dependency
- ☐Chemotherapy
- ☐Circulatory problems
- ☐Cortisone treatments
- ☐Diabetes
- ☐Epilepsy
- ☐Fainting
- ☐Headaches
- ☐Heart murmur
- ☐Heart problems
- ☐Hemophilia
- ☐Hepatitis (Type ___)
- ☐High blood pressure
- ☐HIV/AIDS
- ☐Kidney disease
- ☐Liver disease
- ☐Low blood pressure
- ☐Pacemaker
- ☐Radiation therapy
- ☐Respiratory disease
- ☐Rheumatic fever
- ☐Scarlet fever
- ☐Shortness of breath
- ☐Sleep apnea
- ☐Snoring
- ☐Stroke
- ☐Swelling of feet/ankles
- ☐Thyroid problems
- ☐Tobacco habit
- ☐Tuberculosis
- ☐Ulcer
- ☐Other_______________

Any allergies to the following:

- ☐Latex
- ☐Codeine
- ☐Local anesthetic
- ☐Sulfa
- ☐Penicillin
- ☐Other _________________

To the best of my knowledge, the above information is complete and accurate. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with the company as listed and assign directly to Dr. Katherine Hicks all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance may need during diagnosis and treatment.

*The office schedules individual time with each patient to allow us to deliver the quality, personal care that every patient deserves. I understand that a missed appointment prevents another patient from receiving necessary treatment, and therefore I will be charged $50 should I miss an appointment and fail to cancel 24 hours prior to my appointment.

Signature of patient, guardian or personal representative__________________________Relation (if not self)___________**Date**______________