Patient Update Form **(use back if not enough space)**

Mark if you have any of the following: ☐ Any medical allergies _____

☐Latex, metal allergy or any other dental products (please name) _____

☐Epi sensitive? ☐ Artificial joints or heart valves?_____ **☐Congenital heart conditions?** _____

Patient Name: _____ Patient DOB_____

Patient SS#: _____ Email address: _____

Mailing address:_____ Home Ph:_____

City/State/Zip: _____ Work Ph:_____

Cell Ph: _____ May we use these #s to contact you? _____

May we leave a message on your answering machine/voicemail as a reminder of your appointment? _____

Dental insurance: _____ Group#: _____ ID#:_____

Subscriber name: _____ Subscriber's DOB:_____

Subscriber's Employer:_____Relation to Subscriber? _____

Have there been any changes in your health since last here (ex:surgeries, new diagnosis)? Explain.

_____

Please list all medications you are taking- prescription or over the counter?

_____

Do you have any new dental concerns or problems? Please explain.

_____

The above information is accurate and complete to the best of my knowledge and is only for the use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or her staff responsible for any errors or omissions that I may have made. I authorize my insurance company (if applicable) to assign benefits to Lea H. Fowler, DMD for services rendered. I understand that I am responsible for any and all charges, whether or not paid by insurance. The doctor may release any information necessary to secure the payment of benefits.

Signature:_____ Date: _____

Reviewing doctor:_____ Date:_____

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