Sutton Family Dentistry

## **Patient Update Information**

## **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_  **Sex:** Male / Female

## **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­**

## **Physical** Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­

##  Number & Street City State Zip Code

**Mailing** Address (If different from above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 P.O. Box # City State Zip Code

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­

**Cell Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of **Medical** **Doctor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you **allergic** to or made sick by anything? (Including penicillin, codeine, anesthetic or painkillers?)

Yes / No If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you required to **Premedicate** before dental appointments due to any medical conditions or surgeries?

Yes / No

List **all medications** that you are currently taking, including vitamins, aspirin, etc.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What **pharmacy** do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check any of the following that you have or have had in the past:

\_\_ADHD/ADD \_\_Dizziness \_\_Hip Replacement \_\_Respiratory Problems

\_\_Anemia \_\_Drug Addiction \_\_HIV/AIDS Virus \_\_Rheumatic Fever

\_\_Arthritis \_\_Emphysema \_\_Hypoglycemia \_\_Rheumatic Heart Dis

\_\_Artificial Limbs/Joints \_\_Epilepsy \_\_Jaundice \_\_Rheumatism

\_\_Artificial Heart Valves/Stents \_\_Excessive Bleeding \_\_Kidney Disease \_\_Scarlet Fever

\_\_Asthma \_\_Faintness \_\_Knee Replacement \_\_Seasonal Allergies

\_\_Blood Disease \_\_Frequent Headaches \_\_Leukemia \_\_Seizures

\_\_Cancer \_\_Glaucoma \_\_MitralValveProlapse \_\_Sickle Cell

\_\_Chemotherapy/Radiation \_\_Hay Fever \_\_Nervousness \_\_Sinus Problems

\_\_Circulatory Problems \_\_Heart Attack \_\_Osteoporosis \_\_Stroke

\_\_Congenital Heart Disease \_\_Heart Murmur \_\_Pacemaker \_\_Thyroid Disease

\_\_COPD \_\_Hepatitis A / B /C \_\_Cirrhosis of Liver \_\_Tuberculosis

\_\_Diabetes \_\_High Blood Pressure \_\_Psychiatric Therapy \_\_Ulcers

\_\_Currently Pregnant

Do you have any conditions or problems not listed above? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Names of FAMILY MEMBERS OR OTHERS whom your medical/dental information may be released to, including but not limited to financial/insurance information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_