Update Information

Name _____ Date_____

Section I - update only if there are changes - (skip to Section III if no changes)

Address _____
City _____State _____Zip_____
Home Phone_____ Work Phone _____ Cell Phone_____
Birth Date_____ Marital Status _____ Soc.Sec.#_____-_____-_____
E-mail_____ Sex _____ Local 456: Municipality or Teamsters
Town of _____
Name of Responsible Party_____
Billing Address _____

Full Time Student? School_____

Section II - update only if there are changes - (skip to Section III if no changes)

Primary Dental Insurance

Employee Name _____ Birth Date _____
Soc. Sec # _____-_____-_____Relationship: Spouse Child Self Other
Insurance Company Name _____
& Address _____
_____
Group # _____ Employee/Member ID # _____

Secondary Dental Insurance

Employee Name _____ Birth Date _____
Soc. Sec # _____-_____-_____Relationship: Spouse Child Self Other
Insurance Company Name _____
& Address _____
_____
Group # _____ Employee/Member ID # _____

Section III

1. Have you been hospitalized in the past 5 years? Yes No
   a. Please Explain _____
2. Have you had any serious illnesses or operations? Yes No
   a. Please Explain _____
3. Please list all Medications you take DAILY:
   a. Name_____ Name _____
   b. Name_____ Name _____
   c. Name_____ Name _____
   d. Name_____ Name _____
   e. Name_____ Name _____

4. Do you have, or have you had any of the following?
    a. Heart Disease? Yes No
    b. High Blood Pressure? Yes No
    c. Blood Disorder or Anemia? Yes No
    d. Rheumatic Fever or Heart Murmur? Yes No
    e. A Subacute Bacterial Endocarditis (SBE) Infection? Yes No
    f. Unrepaired Congenital Heart Defect (CHD)? Yes No
    g. Repaired CHD within 6 mos or one that is still leaking? Yes No
    h. A Heart Transplant? Yes No
    i. Artificial Heart (Cardiac) Valve? Yes No
        i. When was it place _____
    j. Artificial Hip, Knee or Joint Replacement? Yes No
        i. When was it placed? _____
    k. Previous Infection in an Artificial Valve, Hip, Knee or Joint? Yes No
    l. Diabetes? Yes No
    m. Stroke? Yes No
    n. Epilepsy or Seizures? Yes No
    o. Fainting Spells? Yes No
    p. Psychiatric Treatment? Yes No
    q. Cancer or Tumors? Yes No
    r. Venereal Disease? Yes No
    s. Radiation or Chemotherapy? Yes No
    t. Liver or Kidney Disease? Yes No
    u. Hepatitis or Jaundice? Yes No
    v. AIDS or HIV Positive? Yes No
    w. Bleeding Disorder or Prolonged Bleeding? Yes No
    x. Asthma? Yes No
    y. Tuberculosis or Emphysema? Yes No
    z. Do you snore or have sleep apnea? Yes No
        i. If yes, do you use a CPAP machine? Yes No
5. Have you ever had an Allergy to any medications? Yes No
    a. Please list all Allergies and type of reaction you had to that medication:
        i. Drug_____ Reaction_____
        ii. Drug_____ Reaction_____
        iii. Drug_____ Reaction_____
        iv. Drug_____ Reaction_____
6. Are you presently taking Aspirin, Coumadin or any Anticoagulant? Yes No
7. Have you ever had a reaction to a Local Anesthetic or Novocain? Yes No
10. Have you ever had an allergy to Nickel or any other Metals? Yes No
11. Do you Smoke, Vape or Chew Tobacco? Yes No
12. Are you currently taking or have you ever taken Fosamax, Zometa, Zoledronate, Aredia or Pamidronate? Yes No
13. Are you Pregnant? Yes No
14. DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED? Yes No
    a. Please Explain _____

Signature _____ Date_____