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574-654-8811

PATIENT INFORMATION AND MEDICAL HISTORY UPDATE

Date: ____________________________

NAME: _________________________________ NICK NAME: _____________ SSN: ___________________ DOB: _____________

HOME PHONE: ____________________________ CELL: _________________________WORK: ____________________________

ADDRESS: ____City: ____________________State: ______Zip: _____________

EMPLOYER: ____ PHONE:___________________________________

COLLEGE ATTENDING: ____ FULL OR PART TIME: ______________________

MARITAL STATUS: SEX: Spouse: _____________________________ Spouse contact phone: _________________________

E-Mail address: ____ Would you benefit from E-reminders for appointments? _________

IF THE PATIENT IS UNDER 18 OR HAS A LEGAL GUARDIAN, PLEASE COMPLETE:

NAME OF PARENTS OR LEGAL GUARDIAN: ____PHONE: ____________________

EMERGENCY CONTACT: ____PHONE: _______________________________

INSURANCE INFORMATION: PLEASE FILL OUT IF NEW OR CHANGED

PRIMARY INSURANCE COVERAGE

SUBSCRIBER NAME: ____ RELATIONSHIP TO PATIENT: ____________________

SS#: _______-_______-____________ DOB: _/_____/______ EMPLOYER NAME: ____________________________________

INSURANCE CO. NAME: ______________________________ ID #: _______________________ PHONE:____________________

SECONDARY INSURANCE COVERAGE

SUBSCRIBER NAME: ____ RELATIONSHIP TO PATIENT: ____________________

SS#: _______-_______-____________ DOB: _/_____/______ EMPLOYER NAME:____________________________________

INSURANCE CO. NAME: ______________________________ ID #: _______________________ PHONE:____________________

Emergency contact not living with you: Name_________________________Phone cell or home: __________________

Whom may we thank for referring you: _____________________________ Date of last Dental Visit:________________

Dentist or office name: ______________________________ Reason for today's visit: _______________________________

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

___ Bad Breath
___ Burning Sensation On Tongue
___ Clicking Or Popping Jaw
___ Food Collection Between Teeth
___ Gums Swollen And Tender
___ Loose Teeth Or Broken Fillings
___ Orthodontic Treatment
___ Sensitivity To Sweets
___ Sensitivity When Biting
___ Bleeding Gums
___ Chew On One Side Of Mouth
___ Dry Mouth
___ Difficulty Flossing
___ Jaw Pain Or Tenderness
___ Mouth Breathing
___ Sensitivity To Heat
___ Pain Around Ear
___ Sores Or Growths
___ Blisters On Lips Or Mouth
___ Smoking Or Chewing Tobacco
___ Fingernail Biting
___ Grinding Teeth
___ Lip Or Cheek Biting
___ Mouth Pain While Brushing
___ Sensitivity To Cold
___ Periodontal Treatment

HEALTH QUESTIONS, PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

___AIDS/HIV
___Anemia
___Arthritis, Rheumatism
___Artificial Heart Valve
___Artificial Joints
___Asthma
___Back Problems
___Bleeding Abnormally With Extractions
___Blood Disease
___Cancer
___Chemical Dependency
___Chemotherapy
___Circulatory Problems
___ Congenital Heart Lesions
___ Cortisone Treatments
___ Cough, Persistent or Bloody
___ Diabetes
___ Emphysema
___ Epilepsy
___ Fainting Or Dizziness
___ Glaucoma
___ Headaches
___Heart Murmur
___Heart Problems
___ Hepatitis: Type: _____
___Herpes
___High Blood Pressure
___Jaundice
___Jaw Pain
___Kidney Disease
___Liver Disease
___Low Blood Pressure
___Mitral Valve Prolapse
___Nervous Problems
___Pacemaker
___Psychiatric Care
___Radiation Treatment
___Respiratory Disease
___Rheumatic Fever
___Scarlet Fever
___Shortness of Breath
___Sinus Trouble
___Skin Rash
___Stroke
___Swelling of Feet or Ankles
___Swollen Neck Glands
___Thyroid Problems
___Tonsillitis
___Tuberculosis
___Tumor/Growth On Head/Neck
___Ulcer
___Venereal Disease
___Weight Loss

Have you had any surgeries where pins, posts, screws, or any other foreign parts were placed: ___________________
Do you wear contact lenses? ____Yes ____No
Women: Are you Pregnant ? ____Yes ____No Due Date: ______________ Are you nursing? ____Yes ____ No

Have you ever taken any of the group of drugs referred to as "Fen-phen"? These Include combinations of Ionimin, Adipex, Fastin, (Brand Names of Phentermine), Pondimin (Fenfluramine_ and Redux (Dexfenfluramine). ___Yes ___No

MEDICATIONS:

Please List ALL medications you are taking. Please ask for a separate paper if there is not enough space. Include prescriptions, over-the-counter medications, and any herbal supplements:

____

____

ALLERGIES:

___Aspirin ___Codeine ___Iodine ___Latex ___Penicillin ___Sulfa ___Local Anesthetic

Other (Please List) ____

Physician's Name ____________________ Phone: (___)_____________ Date of Last Physical: __________________

WE FILE INSURANCE AS A COURTESY TO OUR PATIENTS. YOU ARE RESPONSIBLE FOR FULL PAYMENT OF YOUR ACCOUNT REGARDLESS WHETHER INSURANCE COVERS THE CHARGES. FULL PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED. YOU ALSO UNDERSTAND THAT YOU ARE RESPONSIBLE FOR ANY AND ALL BILLING FEES, COLLECTION FEES, ATTORNEY COLLECTION FEES AND FINANCE CHARGES THAT MAY INCUR. INTEREST AT 1.5 PER MONTH (18% ANNUM) WILL BE ASSESSED ON ALL BALANCES OVER 60 DAYS.

Signature: ____ Date: ________________

Dr Jeffrey Huyvaert
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