

# Patient Information Update

## 1

### PATIENT INFORMATION

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

What do you prefer to be called? \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone(\_\_\_\_) \_\_\_\_\_

E-mail address \_\_\_\_\_

Employer: \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ Pager # (\_\_\_\_) \_\_\_\_\_

Emergency Contact & Phone # \_\_\_\_\_

## 2

### DENTAL INSURANCE

Primary Insurance Name \_\_\_\_\_

Group # \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relation \_\_\_\_\_

Insured's Birthday \_\_\_\_\_ SS# \_\_\_\_\_

Second Insurance Name \_\_\_\_\_

Group # \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relation \_\_\_\_\_

Insured's Birthday \_\_\_\_\_ SS# \_\_\_\_\_

## 3

### MEDICAL HISTORY

Are you currently under the care of a physician?    No    Yes

Please Explain \_\_\_\_\_

Are you taking any prescription/over-the-counter drugs?    No    Yes

Please list each one \_\_\_\_\_

Do you need to be pre-medicated for dental treatment?    No    Yes

For Women: Are you taking birth control pills?    No    Yes

Are you pregnant?    No    Yes

Are you nursing?    No    Yes

Caution: An alternate method of birth control should be used if taking antibiotics.

Have you ever had any of the following diseases or medical problems?

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Attack / Stroke     | <input type="checkbox"/> Psychiatric Problems          |
| <input type="checkbox"/> Cancer / Chemotherapy     | <input type="checkbox"/> Epilepsy / Seizure / Fainting |
| <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Diabetes / Tuberculosis (TB)  |
| <input type="checkbox"/> Rheumatic Fever           | <input type="checkbox"/> Drug / Alcohol Abuse          |
| <input type="checkbox"/> HIV + / AIDS              | <input type="checkbox"/> Hemophilia / Abnormal Bleed   |
| <input type="checkbox"/> Heart Surgery / Pacemaker | <input type="checkbox"/> Congenital Heart Defect       |
| <input type="checkbox"/> Mitral Valve Prolapse     | <input type="checkbox"/> Anemia / Radiation Therapy    |
| <input type="checkbox"/> Kidney Problems           | <input type="checkbox"/> Asthma / Arthritis            |
| <input type="checkbox"/> Artificial Bones / Joints | <input type="checkbox"/> Difficulty Breathing          |
| <input type="checkbox"/> Artificial Valves         | <input type="checkbox"/> Hospitalized                  |
| <input type="checkbox"/> Sinus Problems            | <input type="checkbox"/> Hepatitis                     |
| <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Blood Transfusion             |
| <input type="checkbox"/> Severe / Freq. Headaches  | <input type="checkbox"/> Low Blood Pressure            |
| <input type="checkbox"/> Emphysema / Glaucoma      |  |

Please list any serious medical condition(s) that you have ever had:

\_\_\_\_\_

Are you allergic to any of the following drugs?

- |                         |                        |             |
|-------------------------|------------------------|-------------|
| Y N Penicillin          | Y N Tetracycline       |             |
| Y N Percodan            |                        |             |
| Y N Aspirin             | Y N Dental Anesthetics | Y N Demerol |
| Y N Erythromycin        | Y N Codeine            | Y N Valium  |
| Y N Other (Please List) | _____                  |             |

Do you smoke? \_\_\_\_\_ How much \_\_\_\_\_

Do you use smokeless tobacco? \_\_\_\_\_ How often \_\_\_\_\_

**CONSENT FOR TREATMENT:** I do authorize and give consent to the doctor and his staff to administer treatment, including, but not limited to, local anesthesia, analgesia and other such treatment which may be necessary for the above named patient. I also understand that the use of these agents and some procedures embodies a certain risk. I further state that the above medical and dental history was completed fully and accurately to the best of my knowledge.

I authorize the use of my radiographs and/or photographs for use in seminars or publications of Thomas O. Marxen, D.D.S., M.S.D.

A service charge of 1.5% per month (18% per annum,) but in no event more than the maximum rate permissible under state law will be charged on the unpaid balance on all accounts not paid within 90 days of treatment date. I understand that the responsibility for payment for Dental Services provided in this office for myself or my dependent is mine. Payment is expected at the time of service. I hereby authorize that the payment from any insurance company due me be paid directly to this office. In the event of default in my payment, patient or party responsible for fees agrees to pay any and all cost of suit, collection and attorney's fees. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.