DENTAL HEALTH UPDATE

Please assist us in updating our records by noting any changes since your last visit.

Gregory N. Bigelow, D.M.D., PC. Peter D. Pastrell, D.M.D. Justin D. Buchanan, D.D.S.

Today's Date: _____

Name: _____
LAST FIRST MI MR. MRS. MS. DR.

I prefer to be called:_____ ❑ Male ❑ Female

Mailing Address: _____

_____
CITY STATE ZIP

Birthdate:_____/_____/_____ Age:_____ SS#_____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Drivers License #: _____

Home Phone# _____ Cell# _____

Work Phone# _____ Ext. _____

E-mail address: _____

Employer: _____

Employer's Address: _____

How long there?_____ Occupation: _____

Where and when are best times to reach you? _____

_____

Spouse Info

Spouse's Name: _____

Employer: _____

Wk # : _____ Ext _____

Birthdate:_____ SS# _____

Do you have a personal physician? ❑ No ❑ Yes

Physician's Name:_____

Phone #: _____Date of last visit: _____

Your current physical health is ❑ Good ❑ Fair ❑ Poor

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 _____

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

Are you pregnant? ❑ No ❑ Yes Week # _____

Are you nursing? ❑ No ❑ Yes

_____

Signature Date

Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ____/____/____ Insured's SS# _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ____/____/____ Insured's SS# _____

Insured's Employer: _____

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

Y N	Heart Attack / Stroke	Y N	Psychiatric Problems
Y N	Cancer / Chemotherapy	Y N	Epilepsy / Seizures / Fainting Spells
Y N	Heart Murmur	Y N	Tuberculosis (TB)
Y N	Rheumatic Fever	Y N	Drug / Alcohol Abuse
Y N	HIV + / AIDS	Y N	Venereal Disease
Y N	Heart Surgery / Pacemaker	Y N	Hemophilia / Abnormal Bleeding
Y N	Shingles	Y N	Ulcers / Colitis
Y N	Mitral Valve Prolapse	Y N	Anemia / Radiation Treatment
Y N	Kidney Problems	Y N	Asthma
Y N	Artificial Bones / Joints	Y N	Hospitalized for Any Reason
Y N	Sinus Problems	Y N	Hepatitis
Y N	High / Low Blood Pressure	Y N	Blood Transfusion
Y N	Fever Blisters	Y N	Emphysema / Glaucoma
Y N	Severe / Frequent Headaches	Y N	Thyroid
Y N	Osteoporosis	Y N	Congenital Heart Defect
Y N	Arthritis	Y N	Diabetes

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

_____

Do You smoke? ❑ No ❑ Yes

Are you allergic to any of the following drugs?

Y N	Penicillin	Y N	Tetracycline	Y N	Latex
Y N	Aspirin	Y N	Dental Anesthetics	Y N	Other
Y N	Erythromycin	Y N	Codeine		

Please list any other drugs that you are allergic to:

_____

_____

Update: _____

_____

_____