PATIENT UPDATE FORM

GENERAL INFORMATION

Patient First Name _____Middle Initial ___Last Name _____Nickname_____
Date of Birth _____ Social Security Number _____
Address _____ City _____ State _____ ZIP _____
Email_____ Home Phone _____ Cell Phone _____
Employer_____ Occupation_____ Work Phone _____
Emergency Contact _____ Relationship _____ Phone # _____
Changes to dental insurance since your last visit? □ YES □ NO

COMMUNICATION

Sisson Family Dentistry has permission to contact me with appointment reminders or other communication via the following (check all that apply):

□ Text □ Email Preferred Phone #: □ Home □ Cell □ Work

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, have received/been offered a copy of the office's Notice of Privacy Practices.

I authorize the following person(s) to have access to information covered under the Privacy Practices regarding myself:

Name (Printed)_____ Relationship _____
Name (Printed)_____ Relationship _____

SOCIAL MEDIA RELEASE

I authorize Sisson Family Dentistry to use the following on social media:

□ photographs of teeth/jaws only □ photographs of face □ feedback/written reviews □ first name

MEDICAL HISTORY

Have you had a serious illness or hospitalization in the past 5 years? □ YES □ NO
Have you ever taken any bisphosphonate medications? □ YES □ NO
Are you taking any blood thinner medications? □ YES □ NO
Women: Are you pregnant? □ YES □ NO Nursing? □ YES □ NO
Do you use: Tobacco □ YES □ NO Type _____ Frequency _____
Alcohol □ YES □ NO Frequency_____
Other Drugs □ YES □ NO Type_____ Frequency _____

Check (√) if you have or have had any of the following:

□ Anemia	□ Cancer (Type _____)	□ Heart Problems	□ Pacemaker	□ Other
□ Anxiety	□ Depression	□ Heart Surgery	□ Respiratory Disease	_____
□ Arthritis	□ Diabetes	□ Hepatitis	□ Seizures	_____
□ Artificial Heart Valve	□ Fainting	□ High/Low Blood Pressure	□ Shortness of Breath	_____
□ Artificial Joints	□ GERD	□ HIV/AIDS	□ Stomach Ulcers	
□ Asthma	□ Glaucoma	□ HPV	□ Stroke	
□ Bleed easily	□ Headaches	□ Kidney Disease	□ Thyroid Problems	
□ Blood disorders	□ Heart Attack	□ Liver Disease	□ Tuberculosis	

MEDICATIONS

List medications you are currently taking:

_____
_____
_____
_____

ALLERGIES

□ Aspirin □ Penicillin
□ Sulfa □ Latex
□ Codeine □ Other _____

OVER

The information on this form is accurate and complete to the best of my knowledge and is only for used in my treatment, billing, and processing of insurance benefits. I agree to pay for all professional fees and treatment not covered by my dental insurance. I realize that Sisson Family Dentistry will file my insurance claim as a courtesy and that I am responsible for full payment of fees not paid by my insurance company within 60 days from that date of service. I further agree to

pay any collection fee, attorney fees, and court costs should these means of collection become required. I will not hold the dentist or any of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature_____ Date:_____