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

MUST SIGN FOR OFFICE TO FILE INSURANCE 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 ____________________________

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.

Cancellation Policy

Sisson Family Dentistry requires 24-hour notice for cancelled or failed appointments. Any appointment less than 90 minutes is subject to a $50 cancellation fee. Any appointment 90 minutes or more is subject to a $75 cancellation fee. This fee will be required to be paid before any future appointments can be made. After **3** cancelled or failed appointments, our office reserves the right to not schedule any further appointments.

Patient/Guardian Signature____ Date: _________________