LIEBES DENTAL

PATIENT UPDATE FORM

About You

Today's Date: ___________ Email: ________________________

Name: ____
LAST FIRST M.I.

I prefer to be called: ________________________________

Birthdate: ___ / ___ / ___ Age: ______ SS#: _____________

Home Address: ____________________________________

____
CITY STATE ZIP CODE

Status: SINGLE MARRIED DIVORCED WIDOWED SEPARATED

Home Phone: ____________________ Cell: _____________

Work #: ____________________

Medical History

Do you have a personal Physician? YES NO

Physicians Name: ________________________________

Phone #: __________________ Last Visit Date: __________

Your current physical health is: GOOD FAIR POOR

Are you currently under the care of a physician? YES NO

If yes, please explain: ____________________________

____

____

Are you taking any prescriptions / OTC drugs? YES NO

If yes, please list: ________________________________

____

Are you allergic to any of the following?

Aspirin	Y	N	Latex	Y	N
Any metals or plastics	Y	N	Penicillin	Y	N
Codeine	Y	N	Tetracycline	Y	N
Dental Anesthetics	Y	N	Other	Y	N
Erythromycin	Y	N			

Please list any other drugs / materials you are allergic to:

____

____

For Women:

Are you taking Birth control?	Y	N
Are you Pregnant?	Y	N
If yes, week # _________		
Are you nursing?	Y	N

Dental Insurance (Primary / Secondary)

CIRCLE ONE

Name: ____

Billing Address: ____________________________________

____
CITY STATE ZIP CODE

Phone: ____

Group #: ____

Insured's Name: ____________________________________

Relation: ____________________ Birthdate: ___ / ___ / ____

Insured's SSN#: ____________________________________

Insured's Employer: __________________________________

Employer Address: ___________________________________

____

Employer's Phone #: _________________________________

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

Anemia	Y	N	Heart Surgery	Y	N
Arthritis	Y	N	Abnormal Bleeding	Y	N
Artificial Bones / Joints	Y	N	Hepatitis Type? _____	Y	N
Artificial Valves	Y	N	High / Low Blood Pressure	Y	N
Asthma	Y	N	HIV+ / AIDS	Y	N
Blood Transfusion	Y	N	Hospitalized (any reason)	Y	N
Cancer / Chemotherapy	Y	N	Kidney Problems	Y	N
Congenital Heart Defect	Y	N	Mitral Valve Prolapse	Y	N
Diabetes	Y	N	PsychiatricTreatment	Y	N
Difficulty Breathing	Y	N	Radiation Therapy	Y	N
Drug / Alcohol Abuse	Y	N	Rheumatic / Scarlet Fever	Y	N
Emphysema	Y	N	Shingles	Y	N
Glaucoma	Y	N	Sinus Problems	Y	N
Fainting Spells	Y	N	Tuberculosis (TB)	Y	N
Heart Attack / Stroke	Y	N	Ulcer / Colitis	Y	N
Heart Murmur	Y	N	Venereal Disease (STD)	Y	N

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

____

Emergency Contact

His / Her Name: ____________________________________

Relation: ____

Home Phone: ____

Work Phone: ____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Liebes to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform Dr. Liebes. I authorize my insurance company to pay Dr. Liebes, D.D.S. all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Dr. Liebes, D.D.S. to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charged whether or not paid by insurance.

Signature: ____ Date: ______________