

Stuart H. Rich, DDS, PS
Patient Information Update

Please take a few minutes to answer the questions. For your convenience, if you provide us with an e-mail address **that you check frequently**, we will send appointment reminders to you electronically.

Name: _____ Home phone: _____
Address: _____ Work phone: _____
_____ Cell phone/pager: _____
City,State,Zip: _____ E-mail: _____

Please circle the best method to contact you.

Employer : _____ Spouse's name: _____

Please carefully review this dental insurance information and update it if necessary. If we don't have accurate information, your claims may be delayed.

	<u>Primary coverage</u>	<u>Secondary coverage</u>
Insured Party:	_____	_____
Employer/plan:	_____	_____
Insurance company:	_____	_____

Medical History / Information

Medical Doctor: _____ City _____
Phone: _____

Yr. of last physical exam _____ Yr. of last dental exam _____

In case of Emergency, please contact: _____ Relationship _____
Their Home Phone: _____ Work Phone: _____ Cell: _____

List **ALL MEDICATIONS**(incl. over the counter, vitamins etc) you are currently taking, and **WHY** you are taking them:

ALLERGIC TO:(check if yes) Latex___ Codeine___ Antibiotic___ Dental Anesthetic___
Please List **All Other Allergies** to Medications or Other: _____

Has your dentist or physician recommended you take antibiotics before each routine dental visit? **Y / N**

Please List Any *Surgeries or Hospitalizations* You have had in the last 5yrs: _____

Do you use tobacco? **Y / N** Type: Smoke / Chew / Dip How often? _____ For how many years? _____
For Women: Are you pregnant or nursing? **Y / N** (Due date_____) Are you taking birth control pills? **Y / N**

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Patient: _____ **DOB-** _____

Do you have or have you had any of the following conditions? (Circle Y or N)

- | | | |
|---------------------------------------|---|---|
| Y N Heart attack | Y N Hepatitis A B or C | Y N Anemia |
| Y N Heart Disease | Y N Cancer / Tumors / Biopsies | Y N HIV / AIDS / ARC |
| Y N Heart Surg./ Pacemaker | Y N Leukemia | Y N STD's |
| Y N Mitral Valve Prolapse | Y N Chemotherapy / Radiation | Y N Artificial Joint / yr placed _____ |
| Y N Congenital Heart Defect | Y N Diabetes | Y N Excessive Snoring affects sleep |
| Y N Heart Murmur | Y N Hypoglycemia | Y N TMJ / TMD Problems |
| Y N Artificial Heart Valves | Y N Liver Disease | |
| Y N Chest Pains | Y N Hypothyroid | |
| Y N High Blood Pressure | Y N Hyperthyroid (Graves Disease) | |
| Y N Stroke | Y N Kidney Disease | |
| Y N Rheumatic Fever | Y N Stomach Problems / Ulcer | |
| Y N Scarlet Fever | Y N Arthritis / Rheumatism | |
| Y N Seizures/ Epilepsy | Y N Glaucoma | |
| Y N Respiratory Problems | Y N Shingles | |
| Y N Emphysema | Y N Psychiatric Care | |
| Y N Asthma | Y N Alcohol / Drug Dependency | |
| Y N Sinus Problems | Y N Nervousness | |
| Y N Tuberculosis(TB)when _____ | Y N Unexplained weight gain / loss | |

Please list any other medical conditions not listed: _____

I authorize the staff of Dr. Stuart Rich to perform any necessary services during diagnosis and treatment. I also authorize Dr. Stuart Rich to release any information required to process insurance claims.

I understand the above questions and guarantee that this form was completed correctly to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ **Date:** _____

Please check one: Adult patient Parent or Guardian Spouse

Thank you for assisting us in providing you with excellent care.

For Doctor's Use: _____

Office use only: Reviewed / Dr. Rich: _____ *Date:* _____ *Entered / computer:* _____ *Date:* _____

Last prophylaxis: _____ *BWX:* _____ *FMX:* _____ *Pano:* _____