Patient Update Form

Date:

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I.: _____ Nickname: _____

Date of Birth: _____ Gender: _____ SSN: _____

If patient is a minor, include parent/guardian's name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ ❑Cell ❑ Home ❑ Work E-mail: _____

Emergency Contact: _____ Emergency Phone Number: _____

School: _____ Hobbies, Interests: _____

Siblings name(s) and age(s):

INSURANCE INFORMATION (*if applicable*)

Primary Policy Holder's Name: _____ Date of Birth: _____ SSN: _____

Insurance Company Name: _____ ID #: _____ Group #: _____

Employer: _____

Secondary Insurance (Orthodontic Patients Only):

Policy Holder's Name: _____ Date of Birth: _____ SSN: _____

Insurance Company Name: _____ ID #: _____ Group #: _____

Employer:

MEDICAL UPDATE

Physician: _____ Phone: _____

List all medications (herbals, supplements, OTC): _____ ❑ No Medications

List any allergies (medications, latex, metals, food): _____ ❑ No Allergies

List any hospitalizations (reason & date): _____ ❑ No Hospitalizations

List any surgeries (reason & date): _____ ❑ Adenoidectomy ❑Tonsillectomy ❑ No Surgeries

Is there a history of taking bisphosphonates (i.e. Fosamax)? ❑ Yes, date: _____ ❑ No Bisphosphonates

Is there a history or difficulty with any of the following? ❑ None. Patient is HEALTHY

- ☐ ADD / ADHD
- ☐ Anemia
- ☐ Asthma
- ☐ Autism
- ☐ Bladder Disease
- ☐ Bleeding Disorders
- ☐ Cancer / Chemotherapy / Radiation Therapy
- ☐ Cerebral Palsy
- ☐ Cleft Lip / Palate
- ☐ Cold Sores
- ☐ Developmental Delay
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Emotional / Behavior Concerns
- ☐ Frequent Colds
- ☐ GI Issues / Reflux / Ulcers
- ☐ Hearing Disorders / Deaf
- ☐ Heart Disorders
- ☐ Hepatitis / Liver Disease
- ☐ Kidney Disorders
- ☐ Lung Disease
- ☐ Muscular Problems
- ☐ Premature Birth
- ☐ Psychiatric Disorders
- ☐ Seasonal Allergies
- ☐ Seizures, Epilepsy
- ☐ Sickle Cell Disease
- ☐ Snoring / Sleep Problems
- ☐ Tonsil / Sinus Problems
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Ulcers (GI)
- ☐ Vision Problems
- ☐ Other (*please specify):* _____

Is there any other information we should be aware of that is not mentioned above?

DENTAL HISTORY

Reason for today's visit: _____ ❑ Dental Checkup ❑ Orthodontic Consultation

Have you been evaluated or currently in orthodontic treatment? ❑ No ❑ Yes

Orthodontist's Name: ❑ Dr. Sint ❑ Other: _____ Phone: _____

The American Association of Orthodontics recommends all children get a check up with an orthodontic specialist no later than ***age 7.*** *Dr. Noel Sint, our Board Certified Orthodontist, offers complimentary evaluations for children and adults. Please let us know if you would like additional information.*

_____ _____

Patient / Guardian Signature Relationship to Patient