

# TENNESSEE CENTERS FOR LASER DENTISTRY

(Patient Update Form – For Existing Patients)

PATIENT NAME \_\_\_\_\_ SEX \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

IS IT OKAY TO CONTACT YOU VIA EMAIL? ( YES / NO ) IS IT OKAY TO CONTACT YOU VIA TEXT? ( YES / NO )

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

PLACE OF EMPLOYMENT \_\_\_\_\_ WORK# \_\_\_\_\_ CELL # \_\_\_\_\_

## PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM ABOVE)

NAME \_\_\_\_\_ SEX \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

BILLING ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_ HOME# \_\_\_\_\_ WORK# \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ EMPLOYER \_\_\_\_\_

**\*\*\*\*(HAS YOUR DENTAL INSURANCE CHANGED???) \*\*\*\*\* ( DO YOU HAVE NEW DENTAL INSURANCE????)\*\*\*\***

PRIMARY DENTAL INSURANCE \_\_\_\_\_ POLICY HOLDER'S NAME \_\_\_\_\_

SS# \_\_\_\_\_ ID# / POLICY# \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

## PERSONAL MEDICAL HISTORY (PLEASE ANSWER YES OR NO AND EXPLAIN)

HAVE YOU BEEN HOSPITALIZED SINCE YOUR LAST VISIT? \_\_\_\_\_ IF YES, EXPLAIN \_\_\_\_\_

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? \_\_\_\_\_ IF YES, PHYSICIAN'S NAME \_\_\_\_\_

CURRENT OR RECENT ILLNESS? \_\_\_\_\_ ALLERGIC TO MEDICATION? \_\_\_\_\_

**(DO YOU PREMED FOR DENTAL PROCEDURES?(YES / NO) IF YES, WHAT DO YOU TAKE \_\_\_\_\_)**

ARTIFICIAL JOINTS  HEART TROUBLE  HIGH BLOOD PRESSURE  EMOTIONAL STRESS  DIABETES

PROLONGED BLEEDING  KIDNEY DISEASE  ASTHMA  GLAUCOMA  EPILEPSY  ARTHRITIS  HEPATITIS

ALLERGIC TO ANESTHETIC  TESTED FOR HIV  THYROID DISORDER  ARE YOU PREGNANT?

(LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING) \_\_\_\_\_

Have you ever taken medicine to strengthen your bones? \_\_\_\_\_ If yes, specify \_\_\_\_\_

Have you ever taken Phen Phen or diet medicines? \_\_\_\_\_ If yes, specify \_\_\_\_\_

## EMERGENCY NOTIFICATION

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE# \_\_\_\_\_

