

# **ESTABLISHED PATIENT INFORMATION UPDATE FORM**

**Please Complete and return at time of appointment**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone# \_\_\_\_\_ Cell phone # \_\_\_\_\_

Have you had any changes to your insurance since your last visit? \_\_\_\_ Yes. \_\_\_\_ No. If yes, please provide new insurance cards at check-in.

## **Medical Information:**

Why are you seeing the doctor today? \_\_\_\_\_  
(Chief Complaint)

Since your last visit, have you experienced any change in:

1. Medications \_\_\_\_ Yes \_\_\_\_ No If yes, please list current medications or provide a copy of your current medication list at check-in \_\_\_\_\_

2. Your Health: \_\_\_\_ Yes \_\_\_\_ No If yes, indicate the changes below  
\_\_\_\_\_

a) New Surgeries: \_\_\_\_\_

b) New Hospitalizations (Indicate where, when and why) \_\_\_\_\_

c) New Illnesses/Accidents: \_\_\_\_\_

d) New Tests/Exams: \_\_\_\_\_

e) Other changes: \_\_\_\_\_

f) Are you allergic to any medications? \_\_\_\_ Yes \_\_\_\_ No If yes, please list: \_\_\_\_\_

g) Do you have any artificial joint/prosthesis? \_\_\_\_ Yes \_\_\_\_ No If yes, please list: \_\_\_\_\_

## **Review of Systems:**

### **CARDIAC: Past /Present**

**ENDOCRINE:** Past Present Fever \_\_\_\_ Palpitations/ Diabetes \_\_\_\_ Chills \_\_\_\_ Irregular Heartbeat \_\_\_\_  
Hyperthyroidism \_\_\_\_ Glaucoma \_\_\_\_ Chest Pain \_\_\_\_ Hypothyroidism \_\_\_\_ Cancer \_\_\_\_ Heart Attack \_\_\_\_

**HEMATOLOGIC:** Night Sweats \_\_\_\_ Heart Failure \_\_\_\_ Anemia \_\_\_\_

**CENTRAL NERVOUS SYSTEM:** High Blood Pressure \_\_\_\_ Bleeding disorder \_\_\_\_ Stroke \_\_\_\_ High Cholesterol \_\_\_\_  
Sickle Cell Disease \_\_\_\_ Seizures \_\_\_\_ Peripheral Vas Disease \_\_\_\_ Blood Clot/DVT \_\_\_\_ Blackouts \_\_\_\_

**RESPIRATORY:** Phlebitis \_\_\_\_ Dizziness \_\_\_\_ Cough \_\_\_\_ Bruising \_\_\_\_ Headaches \_\_\_\_ Shortness of Breath \_\_\_\_

**GASTROINTESTINAL:** Visual Problems \_\_\_\_ Asthma \_\_\_\_ Nausea \_\_\_\_ Hearing Problems \_\_\_\_ Tuberculosis \_\_\_\_  
Vomiting \_\_\_\_

**MUSCULOSKELETAL:** Sinus Infection \_\_\_\_ Liver Disorder \_\_\_\_ Rheumatoid Arthritis \_\_\_\_ Pneumonia \_\_\_\_  
Ulcers \_\_\_\_ Osteoporosis \_\_\_\_

**URINARY:** GERD \_\_\_\_ Fibromyalgia \_\_\_\_ Difficulty Urinating \_\_\_\_ Internal Bleeding \_\_\_\_ Birth Defects \_\_\_\_  
Difficulty Urinating \_\_\_\_ Diarrhea \_\_\_\_

**INTEGUMENTARY:** Kidney Problem \_\_\_\_ Rashes \_\_\_\_ Prostate enlargement \_\_\_\_

Burns \_\_\_\_ I have none of the conditions/symptoms listed above \_\_\_\_ Initials

Do you have HIV/AIDS? \_\_\_\_ Yes \_\_\_\_ No MRSA? \_\_\_\_ Yes \_\_\_\_ No

Hepatitis? \_\_\_\_ Yes \_\_\_\_ No If yes, \_\_\_\_ Type A \_\_\_\_ Type B \_\_\_\_ Type C

**I CERTIFY TO THE BEST OF MY KNOWLEDGE THAT THE INFORMATION THAT I HAVE PROVIDED IS ACCURATE:**

**PATIENT signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**AUTHORIZATION/CONSENT FOR EXAMINATION AND TREATMENT:**

I hereby acknowledge that I have voluntarily presented myself, or my child (if patient is a minor) for dental treatment at Team Dental at River Oaks

**RELEASE OF MEDICAL INFORMATION:** I authorize the Doctors of Team Dental at River Oaks to release any information concerning my care to my insurance company. I also authorize the release of information to any agency necessary for payment on my account. I authorize Team Dental at River Oaks to release records to any doctor and/or medical facility that they deem pertinent to my care.

**ASSIGNMENT OF BENEFITS:**

I request that the payment of authorized Dental and/or Insurance benefits be made on my behalf. I assign benefits to the doctor or organization furnishing services.

Are you the primary holder on your insurance? \_\_\_\_\_ Yes. \_\_\_\_\_ No.

If No, please complete the following **Guarantor Information:**

**Guarantor Name:** \_\_\_\_\_

**Guarantor Address:** \_\_\_\_\_ **Tel #** \_\_\_\_\_ (if different from yours)

**Guarantor Date of Birth:** \_\_\_\_\_ **Social Security Number** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_

Please be prepared to provide a copy of your insurance cards and photo ID at check-in, if requested.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE AUTHORIZATIONS. I CERTIFY TO THE BEST OF MY KNOWLEDGE THAT THE INFORMATION THAT I HAVE PROVIDED IS ACCURATE:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_