ANNUAL HEALTH/PATIENT INFORMATION UPDATE

Name _____
Last First Middle Initial

New address information _____
Street City State Zip Code

Home Phone_____ □ Not okay to leave message with detailed information.

Cell Phone_____ □ Not okay to leave message with detailed information.

Email_____

INSURANCE: If insurance has changed, please give your information or insurance card to the front desk.

Yes □ No □ Has there been any change in your health since your last appointment?

If yes, please explain: _____

Do you use tobacco products? Yes □ No □ If yes, list type, amount & how long _____

Do you drink alcohol? Yes □ No □ If yes, list type, amount & how frequently _____

Yes □ No □ Are you taking medications of any kind, prescribed or over the counter, at this time? If yes, please list:

Drug	**Dose/Frequency**	**Reason for taking**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yes □ No □ Are you allergic to any medications or substances? If yes, please check box below:

□LIDOCAIN □MEPIVACAIN □PENICILLIN □CODEIN □ASPIRIN □SULFA □LATEX
□Other _____

Yes □ No □ Have you ever had any of the following? Please check those that apply:

___High blood pressure	___Thyroid disease	___Diabetes: _____
___Heart disease, Heart Murmur	___Kidney disease	___Venereal disease
___Rheumatic fever	___Hemophilia	(Syphilis, Gonorrhea)
___Artificial heart valve	___Mental illness	___Asthma
___Artificial joint	___Cancer, Leukemia	___Hepatitis:_____
___Pacemaker	___Tuberculosis	___Epilepsy
___Anemia	___Ulcer	___AIDS or HIV
___Sleep apnea	___Nervousness/anxiety	___Radiation therapy
___Breast Cancer Treatment	___Immune suppression	___Osteoporosis
___Blood thinner (Coumadin/Wafarin)	___Other _____	

(WOMEN ONLY) Are you pregnant? □ Yes □ No Due Date: _____ Nursing: □ Yes □ No

- **I was informed about the "no-shows or within-24-hours cancellation" policy. Violation of this policy will result in a charge of $30 per an appointment or discontinuation of service. For OHP patients, discontinuation status will be reported to ODS or CDC. This may result in a disqualification in my future coverage.**
- **Deductible and co-pay are due at time of service unless prior arrangements were made. A $50 will be charged for returned checks.**

_____
PATIENT/GUARDIAN SIGNATURE DATE

_____
DR/HYG. SIGNATURE DATE