ORAL HEALTH UPDATE

To provide you with optimum care, please take a few moments to complete, sign, and date the following:

(Please print)
Patient Information:
Name: _____Nick Name: _____
Address: _____
City: _____ State: _____ Zip code: _____
Home Number: _____ Work Number: _____ ext.:_____
Date of Birth: _____ E-Mail: _____
Employer: _____

Dental Insurance:
Carrier Name: _____ Group #:_____
Employee: _____ Date of Birth: _____
Employer: _____ SS #: _____
Secondary Dental Insurance Company: _____
Employee: _____ Employer: _____
SS #: _____ Date of Birth: _____

Medical History:
Please list any medications, pills, or drugs _____
_____

Signature: _____ Date: _____
Thank you for taking the time to complete this form: We take pride in educating our dental patients and leading the way to a "healthier smile".