FAIRBANKS Fairbanks Dental Associates

YEARLY PATIENT INFORMATION UPDATE

LAS	Г NAME:	NICKNAME:	
ADDRESS:	CITY:	STATE:	_ ZIP:
SEX: M F MARITAL STATUS: M S D W SOC.	SEC. #:	DOB:	
CELL PHONE: HOME PH			
*IN CASE OF EMERGENCY PLEASE NOTIFY	RELATIONSHIP TO PATIENT:	PHONE:	
ANY CHANGES TO YOUR DENTAL INSURANCE: YES NO	IF YES- DENTAL INSURANCE NAME:		
SUBSCRIBER'S NAME:	SUBSCRIBER'S DOB:	RELATIONSHIP TO PATIEN	NT:
SUBSCRIBER ID/SS#:	GROUP/PLAN#		
Current Tobacco Product use? Y N If yes,v	/hat products do/did you use?	E-Cigs ? YesNo	_
DO YOU HAVE OR EVER HAD ANY OF THE FOL	LOWING? (please place a check m	ark beside each condition that appl	ies)
Blood disorders Stroke	Diabetes	Fainting	
Heart disease Lung disease	Epilepsy	Arthritis	
Heart attack Tuberculosis	Anemia	Seasonal Allergies	
Heart murmur Asthma	Tumor history	Pregnant if yes, due date	
Rheumatic fever Liver disease	Artificial joints	Glaucoma	
Chest pains (Angina) Hepatitis	High blood pressure	Herpes Simplex Virus	
AIDS / HIV+ Kidney disease	Low blood pressure	Human Papilloma Virus	_
Padget's Disease Multiple Myelor		Gum Disease, did you receiv	e treatment?
Systemic Lupus AcidReflux	Eating Disorder	Osteoporosis	
Sleep Apnea Cancer	Psychiatric treatment	Bisphosphonate Drug Use (C	Osteoporosis Drug)
**** NONE OF THE ABOVE CONDITIONS APPLY	TO ME		
OTHER SYSTEMIC CONDITIONS/ Please explain a	ny checked conditions:		
MEDICATION ALLERGIES (please check all that a	pply) No Known Drug Allergies	Amoxicillin Aspirin	Clindamycin
Codeine Erythromycin Ibuprofen I	Penicillin Other:		
ARE YOU TAKING ANY DRUGS, MEDICATION,	OR PILLS? Y N Please list with r	reason for each medication	
HAVE YOU EVER BEEN HOSPITALIZED OR HAD	SURGERY? Y N EXPLAIN:		
RESPONSIBLE PARTY SIGNATURE		DATE	
		~ ~	
DOCTOR SIGNATURE DATE			
		2	_
HIP	AA Policy, Texas SB-300 and Consel		_
Purpose of Consent: By signing this form, you will	consent to our use and disclosure of	<i>nt</i> your protected health information to	– o carry out treatment,
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Signature:____

Date:___

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