# Patient Information Update

**Patient Name:**_____________________________________**Date:**______________**SSN**_____________________________
**Street Address:**______________________**City**________________**State**___**ZipCode**_______ **E-mail:** __________________
**Home:** _________________________**Work:** __________________________**Cell:** ___________________________

**Preferred Contact Method:** ☐ E-mail ☐ Home ☐ Cell ☐ Work
**Prefer Appointment Times:** ☐AM ☐PM **Day of the Week:** ☐M ☐T ☐W ☐Th

## Health Information: Changes?

*Have you ever had any of the following conditions?* ***Please check all that apply.***

☐ AIDS/HIV+
☐ Anemia
☐ Arthritis
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy/Seizures
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy: Due________
☐ Radiation Treatment/Chemo
☐ Respiratory Problems
☐ Sinus Problems
☐ Respiratory Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Condition
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ _____________
☐ **Allergies** (Any Drugs, Rx, Codeine) __________
_______________________________________
☐ **Current Rx:(**Birth Control, Cortisone/Steroids)
_______________________________________
_______________________________________

- Reason for this today's Visit? (Other than standard follow-up): __________________________________________________
- Have you been told that **you need pre-medication before any dental procedure?** ☐Yes ☐No
- Have there been **any changes in your health since your last visit?** ☐Yes ☐No If yes, please explain _______________
- Are you now under the care of a physician? ☐Yes ☐No Physician's Name __________________ Phone: _______________

## Insurance Information: Changes?

**Has your dental insurance changed?** ☐Yes ☐No. **If Yes**, please present your new card to expedite your claims processing.
To the best of my knowledge, all information provided is true. **If I have any change in my health**, I will inform the dentist.

## Confirming Your Appointment

**Confirming appointments is very important to us**. When we schedule an appointment, *you* are the *only* person that our providers see at that time. As a courtesy, we will call or send a postcard to confirm your scheduled appointment (and we will place a *reminder call the day before* the appointment). **Please check one of the courtesy confirmation options (below)** that you prefer.

☐ **Please call me to confirm my appointment**; and **I will return the call or e-mail to confirm** my reserved appointment.

☐ **Please call to confirm my scheduled appointment and just leave a message.** I will understand that if I do not make my appointment that the fee will be charged to my credit card.

Credit Card #__________________________________ Expiration Date ________________ Zip Code _______________

**If you ever need to reschedule an appointment, please provide us with 2-business days notice** to avoid any charges, as this will allow us to fill your appointment time with someone who is waiting for an appointment. We reserve the right to charge for missed appointments or short-notice cancellations. With notice, we will gladly reschedule your appointment to meet your needs.

**Running on time is very important to us, as well as to you.** Unfortunately, we *may* be unable to see someone who arrives 15 minutes late for an appointment, or we may be able to complete only part of the treatment; and there could be a broken appointment fee if we do not have enough time to begin your treatment. *So please help us by arriving on time!*

*Thank you for your understanding,*
*Dr. Gary E. Taylor and your OAFD Team*

_______________________________________________________ _____________________________
*Signature of Patient, Parent/Guardian* *Date*