Annual Patient Information Update

Patient Information

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.

First Name _____ M.I. ____ Last Name _____

Preferred Name _____ Gender ❑ Male ❑ Female

Birth Date _____ Age _____ Soc. Sec. # _____ Email _____

Cell (____) _____ Home (____) _____ Work (____) _____

Home Address _____ Apt/Unit _____

City _____ State _____ Zip _____

Student ❑ Full Time ❑ Part Time ❑ N/A School Name _____

Employed ❑ Full Time ❑ Part Time ❑ Retired ❑ N/A

Employer _____ Occupation _____

United States Armed Forces Member? ❑ Current ❑ Former/Retired Branch _____ Rank _____

Marital Status ❑ Married ❑ Engaged ❑ Single ❑ Widowed

Spouse/Partner _____ Employer _____ Occupation_____

Primary Care Physician _____ Tel. (____) _____

Cardiologist _____ Tel. (____) _____

Preferred Pharmacy _____ Tel. (____) _____ Location_____

Emergency Contact Name _____ Tel. (____) _____ Relationship _____

❑ I authorize Britten Dental Associates to share all my protected health information with the following individuals; however, I understand that I may revoke this consent, in writing, at any time; I acknowledge that any use or disclosure that occurs prior to the date I revoke this consent is not affected:

Name_____ Relationship_____ Tel. (____) _____

Name_____ Relationship_____ Tel. (____) _____

Current Dental Insurance:

❑ No changes have been made, **information on file is correct.**

❑ Yes, new insurance information is provided below.

Insured Party's First Name _____ Last Name _____ D.O.B___/___/_____

Relationship to Patient _____ Employer _____

Ins. Co. Name _____ Ins. Co. Tel. (____) _____

ID # _____ Group # _____

Annual Patient Medical Update

Patient Information:

First Name _____ M.I. __ Last Name _____

The following health information you provide insures the overall quality of care Dr. Britten and his staff will provided for you.

Health History

Please list all the medications you are currently taking and why. (include non-prescription, herbs, and supplements)

Medication	Reason	Medication	Reason
_____	- _____	_____	- _____
_____	- _____	_____	- _____
_____	- _____	_____	- _____
_____	- _____	_____	- _____

Have you ever:

Taken Fosamax, Boniva, Actonel, or other medications containing bisphosphonates Osteoporosis/Osteopenia?

❑ No ❑ Yes When was your the last dose? _____

Had a physician ever recommended that you take antibiotics prior to your dental treatment?

❑ No ❑ Yes If yes, please elaborate:

Who recommended the antibiotic _____ Tel. (____) _____

For what reason _____ For how long _____

Have you ever had any of the following conditions/treatments?

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Heart Attack_____
- ❑ Congestive Heart Failure
- ❑ Cardiac Stents_____
- ❑ Cardiac Pacemaker_____
- ❑ Coronary Bypass _____
- ❑ Chest Pain/Angina
- ❑ Congenital Heart Defect
- ❑ Artificial Heart Valve_____
- ❑ Bacterial Endocarditis_____
- ❑ Stroke_____
- ❑ Cancer_____
- ❑ Chemotherapy_____
- ❑ Radiation Therapy_____
- ❑ Family History of Oral Cancer
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Artificial Joint_____
- ❑ Osteoporosis or Osteopenia
- ❑ Psoriasis
- ❑ Lupus
- ❑ Thyroid Disease
- ❑ Emphysema
- ❑ Asthma
- ❑ Pneumonia
- ❑ Bronchitis
- ❑ Tuberculosis
- ❑ Respiratory Problems
- ❑ HPV
- ❑ Cold Sores/Fever Blisters
- ❑ Canker Sores
- ❑ Chickenpox or Shingles
- ❑ AIDS/HIV+
- ❑ Diabetes Type I
- ❑ Diabetes Type II
- ❑ Hypoglycemic
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Liver Disease
- ❑ Bruise/Bleeds Easily/On Blood Thinners
- ❑ Anemia
- ❑ Hemophilia
- ❑ Kidney Disease
- ❑ Depression
- ❑ Nervousness/Anxiety
- ❑ Fibromyalgia
- ❑ Vertigo
- ❑ Neck or Back Injury/Pain
- ❑ Migraine Headaches
- ❑ Tension Headaches
- ❑ Epilepsy/Seizures
- ❑ Substance Abuse
- ❑ Acid Reflux
- ❑ Colitis
- ❑ Diverticulitis
- ❑ Ulcers
- ❑ GI Disorders
- ❑ Snoring
- ❑ Sleep Apnea

❑ Other_____

_____

Notes:_____

_____

_____

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_____

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_____

For Women:

- ❑ Pregnant _____ Weeks
- ❑ Trying to Get Pregnant/In Treatment
- ❑ Nursing
- ❑ Prescription Birth Control

Have you ever had an allergic or adverse reaction to any of the following?

- ❑ Local Anesthetics
- ❑ Nitrous Oxide
- ❑ Latex
- ❑ Acrylic
- ❑ Eugenol (Clove Oil)
- ❑ Aspirin/Ibuprofin
- ❑ Erythromycin or Clindamycin or Azithromycin
- ❑ Penicillin or Amoxicillin
- ❑ Sulfa Drugs (Septra, Bactrim, etc.)
- ❑ Tetracycline or Doxycycline
- ❑ Adhesive Bandages
- ❑ Any Metals (Nickel, etc.)
- ❑ Codeine
- ❑ Sedatives (Valium, Xanax, Versed, Sodium Pentothal, etc.)

❑ Other _____

_____

_____

Your answers are for our records only and are confidential. I herby state that all the information is current and correct.

Patient Signature _____ Date ____/____/_____