C&W Dentistry LLC

"Dentistry from our family to yours."

Plymouth Dental Care ~Winsted Dental Care

Yearly Patient Update Form

Patient Number _____

Name _____ Date _____

SS#/SIN _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

Please let the front desk know if there are any changes with your insurance information.

Does Your Cell Phone Accept Texts? _____

Yearly Patient Medical Survey

1. Are you under medical treatment now? ☐ Yes ☐ No

2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years? ☐ Yes ☐ No

If yes, please explain _____

3. Are you taking any medications(s) including non-prescription medicine? ☐ Yes ☐ No

If yes, what medication(s) are you taking? _____

4. Have you ever taken Fen-Phen/Redux? ☐ Yes ☐ No

5. Do you use tobacco? ☐ Yes ☐ No

6. Are you wearing contact lenses? ☐ Yes ☐ No

8. Are you allergic to or have you had any reactions to the following?

Local Anesthetics (e.g. Novocaine)	☐ Yes	☐ No
Penicillin or any other Antibiotics	☐ Yes	☐ No
Sulfa Drugs	☐ Yes	☐ No
Barbiturates	☐ Yes	☐ No
Iodine	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No
Any Metals (e.g. nickel, mercury, etc.)	☐ Yes	☐ No
Latex Rubber	☐ Yes	☐ No
Other _____	☐ Yes	☐ No

9. WOMEN ONLY:

Are you pregnant or think you may be pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No
Are you taking oral contraceptives?	☐ Yes	☐ No

7. Do you have or had any of the following?

High Blood Pressure	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Chest Pains	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Cardiac Pacemaker	☐ Yes	☐ No	Easily Winded	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Swollen Ankles	☐ Yes	☐ No	Angina	☐ Yes	☐ No	Hay Fever/Allergies	☐ Yes	☐ No
Fainting Seizures	☐ Yes	☐ No	Frequently Tired	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Epilepsy/Convulsions	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Joint Replacement or Implant	☐ Yes	☐ No	Heart Trouble	☐ Yes	☐ No
Kidney Diabetes	☐ Yes	☐ No	Hepatitis/Jaundice	☐ Yes	☐ No	Respiratory Problems	☐ Yes	☐ No
AIDS or HIV Infection	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Thyroid Problem	☐ Yes	☐ No	Stomach Troubles/Ulcers	☐ Yes	☐ No	Other _____	☐ Yes	☐ No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I athorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less then the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor)

Doctor's Comments: _____

_____ Signature _____ Date _____