MEDICAL AND BENEFIT INFORMATION UPDATE

Patient Name: _____
Last, First MI (Preferred Name)

Email Address: _____ Gender: _____

Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Have you ever had any of the following? Please check those that apply

- ☐ AIDS/HIV
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma/COPD/ Bronchitis
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes Type 1 or 2
- ☐ Dizziness
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease/Cardiac Stents/CHF
- ☐ Mitral Valve Prolapse
- ☐ Hepatitis A, B or C
- ☐ High Blood Pressure
- ☐ Jaundice/Liver problems
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due date: _____
- ☐ Nursing baby? Yes or No
- ☐ Radiation Treatment
- ☐ Thyroid Disorders
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ GERD/ Stomach Problems
- ☐ Strokes
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ _____
- ☐ _____
- ☐ _____

What medications and supplements/vitamins do you take? _____

Do you smoke cigarettes/cigars or chew tobacco? ☐ Yes ☐ No

Do you take recreational drugs? ☐ Yes ☐ No

Do you drink herbal teas or homeopathic supplements? ☐ Yes ☐ No

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

Current Dental Insurance Provider: _____ **Subscriber Name:** _____

To the best of my knowledge, all of the information provided is true and correct. If I have any change in my health, I will inform Dr. Varghese John and/or his team at my next appointment without fail. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Varghese John may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will remain in place for all services rendered unless revoked in writing by me, the patient.

Print Patient Name: _____

Patient or Guardian Signature: _____ Date: _____