ANNUAL HEALTH/PATIENT INFORMATION UPDATE

Name _____
Last First Middle Initial

New address information _____
Street City State Zip Code

Home Phone_____ ☐ Not okay to leave message with detailed information.

Cell Phone_____ ☐ Not okay to leave message with detailed information.

Email_____

INSURANCE: If insurance has changed, please give your information or insurance card to the front desk.

Yes ☐ No ☐ Has there been any change in your health since your last appointment?

If yes, please explain: _____

Do you use tobacco products? Yes ☐ No ☐ If yes, list type, amount & how long _____

Do you drink alcohol? Yes ☐ No ☐ If yes, list type, amount & how frequently _____

Yes ☐ No ☐ Are you taking medications of any kind, prescribed or over the counter, at this time? If yes, please list:

Drug	**Dose/Frequency**	**Reason for taking**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yes ☐ No ☐ Are you allergic to any medications or substances? If yes, please check box below:

☐LIDOCAIN ☐MEPIVACAIN ☐PENICILLIN ☐CODEIN ☐ASPIRIN ☐SULFA ☐LATEX
☐Other _____

Yes ☐ No ☐ Have you ever had any of the following? Please check those that apply:

___High blood pressure
___Heart disease, Heart Murmur
___Rheumatic fever
___Artificial heart valve
___Artificial joint
___Pacemaker
___Anemia
___Sleep apnea
___Breast Cancer Treatment
___Blood thinner (Coumadin/Wafarin)
___Other _____

___Thyroid disease
___Kidney disease
___Hemophilia
___Mental illness
___Cancer, Leukemia
___Tuberculosis
___Ulcer
___Nervousness/anxiety
___Immune suppression
___Erectile Dysfunction (Viagra, Cialis, Levitra)

___Diabetes: _____
___Venereal disease (Syphilis, Gonorrhea)
___Asthma
___Hepatitis:_____
___Epilepsy
___AIDS or HIV
___Radiation therapy
___Osteoporosis (Fosamax, Actonel, Bonvia)

(WOMEN ONLY) Are you pregnant? ☐ Yes ☐ No Due Date: _____ Nursing: ☐ Yes ☐ No

- **I was informed about the "no-shows or within-24-hours cancellation" policy. Violation of this policy will result in a charge of $30 per an appointment or discontinuation of service. For OHP patients, discontinuation status will be reported to ODS or CDC. This may result in a disqualification in my future coverage.**
- **Deductible and co-pay are due at time of service unless prior arrangements were made. A $50 will be charged for returned checks.**

_____
PATIENT/GUARDIAN SIGNATURE DATE

_____
DR/HYG. SIGNATURE DATE