Greater Baltimore Prosthodontics, P.A. 110 West Road - Suite 200 -Towson, MD Tel 410-296-0136

PATIENT UPDATE FORM

Name:_____Date of Birth_____

Address:_____City/State/Zip_____

Home Phone:_____Work Phone:_____Cell Phone:_____

E-Mail:_____

Dental Insurance Name:_____ **Subscriber Name:**_____

Subscriber's Employer:_____ **Subscriber's ID#:**_____ **DOB:**_____

Have you ever had:

____Aids	____Excessive Bleeding	____Liver Disease	____Stomach Problems
____Allergies	____Fainting	____Mental Disorders	____Stroke
____Anemia	____Glaucoma	____Nervous Disorders	____Tuberculosis
____Arthritis	____Hay Fever	____Pacemaker	____Tumors
____Artificial Joints	____Head Injuries	____Currently Pregnant	____Ulcers
____Asthma	____Heart Disease	Due Date:_____	____Venereal Disease
____Blood Disease	____Heart Murmur	____Radiation Treatment	____Codeine Allergy
____Cancer	____Hepatitis	____Respiratory Problems	____Penicillin Allergy
____Diabetes	____High Blood Pressure	____Rheumatic Fever	Other:
____Dizziness	____Jaundice	____Rheumatism	_____
____Epilepsy	____Kidney Disease	____Sinus Problems	_____

Please List all Medications you are taking:_____

_____

Emergency Contact:_____ Phone:_____ Relationship to Patient:_____

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_____

Name of Physician_____Phone:_____

Do you have health problems that need further clarification? Yes____ No____
If Yes please explain_____

To the best of my knowledge all the preceding answers and information provided are true and correct.
If I ever have a change in my health, I will inform the doctors the next appointment without fail.

CONSENT & PRIVACY INFORMATION:

I authorize the taking of x-rays, study models, photographs or other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize the dental treatment, medication, and therapy that may be indicated.

I also understand that all dental procedures and the use of anesthetic agents carry a certain risk.

To the extent necessary to determine payment and to obtain reimbursement, I authorize disclosure of my record and agree to release protected health information needed to carry out treatment, payment activities and healthcare procedures.

I understand that I am financially responsible for all charges and payment is due at time of service.

I have seen or received a copy of this office's Notice of Privacy Practices.
My signature on this form is my acknowledgement and consent to the above.

Patient Signature:_____(Seal) Date:_____