PATIENT UPDATE FORM

GENERAL INFORMATION

Patient First Name _____Middle Initial ___Last Name _____Nickname_____
□ Male □ Female Date of Birth _____ Social Security Number _____
Address _____ City _____ State _____ ZIP _____
Email_____ Home Phone _____ Cell Phone _____
Employer_____ Occupation_____ Work Phone _____
Emergency Contact _____ Relationship _____ Phone # _____
Changes to dental insurance since your last visit? □ YES □ NO

COMMUNICATION

Cumberland Pointe Dental has permission to contact me with appointment reminders or other communication via the following (check all that apply):

□ Text □ Email Preferred Phone #: □ Home □ Cell □ Work

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, have received/been offered a copy of the office's Notice of Privacy Practices.

I authorize the following person(s) to have access to information covered under the Privacy Practices regarding myself:

Name (Printed)_____ Relationship _____
Name (Printed)_____ Relationship _____

SOCIAL MEDIA RELEASE

I authorize Cumberland Pointe Dental to use the following on social media:

□ photographs of teeth/jaws only □ photographs of face □ feedback/written reviews □ first name

MEDICAL HISTORY

Have you had a serious illness or hospitalization in the past 5 years? □ YES □ NO
Have you ever taken any bisphosphonate medications? □ YES □ NO
Are you taking any blood thinner medications? □ YES □ NO
Women: Are you pregnant? □ YES □ NO Nursing? □ YES □ NO
Do you use: Tobacco □ YES □ NO Type _____ Frequency _____
Alcohol □ YES □ NO Frequency_____
Other Drugs □ YES □ NO Type_____ Frequency _____

Check (√) if you have or have had any of the following:

□ Anemia	□ Cancer (Type _____)	□ Heart Problems	□ Pacemaker	□ Other
□ Anxiety	□ Depression	□ Heart Surgery	□ Respiratory Disease	_____
□ Arthritis	□ Diabetes	□ Hepatitis	□ Seizures	_____
□ Artificial Heart Valve	□ Fainting	□ High/Low Blood Pressure	□ Shortness of Breath	_____
□ Artificial Joints	□ GERD	□ HIV/AIDS	□ Stomach Ulcers	
□ Asthma	□ Glaucoma	□ HPV	□ Stroke	
□ Bleed easily	□ Headaches	□ Kidney Disease	□ Thyroid Problems	
□ Blood disorders	□ Heart Attack	□ Liver Disease	□ Tuberculosis	

MEDICATIONS

List medications you are currently taking:

_____
_____
_____
_____

ALLERGIES

□ Aspirin □ Penicillin
□ Sulfa □ Latex
□ Codeine □ Other _____

SIGNATURE

Patient/Guardian Signature_____ Date:_____