Madeline Utterback
D.M.D., F.A.G.D.
General, Cosmetic and Implant Dentistry

2020

PATIENT INFORMATION UPDATE

Please indicate any changes in the past 12 months

Name_____ Date: _____
Last First Middle (Preferred Name)

Address_____Apt_____City_____ State_____Zip_____

Cell Phone ( )_____ Home Phone ( )_____ Work Phone ( )_____

Email Address_____

Employer Name_____ Occupation_____
Full time college students, please indicate name of school

Address_____Apt____City_____ State_____Zip_____

Have there been any changes to your **DENTAL INSURANCE**? ☐ Yes ☐ No **If yes, please update**

Insurance Name: _____

Address: _____ Phone number: _____

ID Number: _____ Group Number: _____

Subscriber Name: _____ Birth date: _____ SSN: _____

AUTHORIZATION

I hereby authorize payment directly to Dr Madeline Utterback of the insurance benefits otherwise payable to me. I understand that I am responsible for all costs of my dental treatment. Any and all appeals to insurance will be handled by me. Non insurance payments are due at the time of service. I hereby authorize Dr Madeline Utterback to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and my health history are correct to the best of my knowledge. I grant to this practice the right to release my records/health history and information about my dental treatment to third party payers and/or other health professionals by any method including electronic transfer.

Patient or Responsible Party Signature_____ **Date**_____

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HEALTH INFORMATION

Please indicate any changes in the past 12 months

Primary Physician: _____ Phone: _____ City:_____
Date of last physical examination:_____

Other Physicians & Specialist
Name: _____ Specialty: _____ Phone: _____ City: _____
Name: _____ Specialty: _____ Phone: _____ City: _____

Pharmacy Name:_____ City:_____

1. Within the last 12 months, have you been hospitalized or had surgery? ☐ Yes ☐ No
If Yes, please give reasons and dates: _____

2. Have you ever been instructed to take ANY **medications** or take ANY special precautions **before any dental appointment**? ☐ Yes ☐ No

3. Are you **taking any drugs, medications, or treatments** at this time? ☐ Yes ☐ No
(If you have a complete written list with you, give that to the receptionist instead)

Prescribed: _____
_____
Over the Counter (OTC) medications (such as Aspirin, Advil, allergy medication, etc):
_____
Vitamins, natural or herbal preparations and/or dietary supplements:
_____

4. Are you taking or have you ever taken Fosamax? ☐ Yes ☐ No

5. Are you **allergic** to or have you ever experienced an unusual reaction to:
_____Latex _____Metals or jewelry _____Dental anesthesia (local)
_____Fluoride _____Nitrous oxide (laughing gas) _____General anesthesia

6. Are you **allergic** to or have you ever had any reactions to any of the following drugs?
_____Penicillin (or related drugs) _____Tranquilizers (Valium) _____Tetra cycline
_____Aspirin / Ibuprofen (Advil, Motrin, Nuprin) _____Keflex (Cephalexin) _____Sulfa drugs
_____NSAID (Celebrex, Vioxx, Anaprox) _____Clindamycin (Cleocin) _____Erythromycin
_____Codeine _____Iodine _____Amoxicillin

7. Have you had an allergic reaction or unusual response to ANY other medications, drugs, pills, or treatments? ☐ Yes ☐ No
If yes, please list: _____

Continued on next page…

8. Do you have, or have you ever had, any of the following? (Please check what applies)

_____Anemia
_____Arthritis
_____Any artificial joint, joint surgery, or prosthesis
If yes, what joint or area: _____
When was operation done: _____
_____Asthma
_____Blood Disease / Hemophilia
_____Any form of cancer, Tumor, Radiation Treatment
_____Cerebral palsy
_____Diabetes or blood sugar problems
_____Dizziness/Fainting
_____Epilepsy or other seizure disorder
_____Excessive bleeding from any cut or incident
_____Glaucoma or any eye diseases
_____Head Injury
_____Heart surgery, type & date_____
_____Heart attack, date_____
_____Congenital heart defects
_____Angina or chest pains
_____Atherosclerosis
_____Congestive heart failure
_____Coronary artery disease
_____Infective Endocarditis
_____Heart valve(s) damage / Mitral valve prolapsed
_____Artificial heart valve
_____Hepatitis, jaundice, or other liver problems
_____High Blood Pressure
_____A compromised immune system
(Lupus, HIV, AIDS, etc)
_____Any kidney problems
_____Low Blood Pressure
_____Any mental health issues
_____Been treated for any psychiatric condition
_____Multiple sclerosis
_____An organ transplant
_____Pacemaker
_____Respiratory Problems
_____Sinus problems
_____Skin problems
_____Ulcers, acid reflux, or stomach problems
_____Stroke or CVA
_____A Thyroid problem or disease
_____Tuberculosis, emphysema or lung disorder
_____An active sexually transmitted disease (STD)

Women Only:
_____Are you pregnant, due date: _____
_____Do you think you might be pregnant
_____Are you presently nursing
_____Are you using birth control medication
_____Are you taking hormone replacement theraphy

9. Do you have any other conditions, diseases, or medical problems, or is there ANY other information that you would like us to know about, or that we should be made aware of? ☐ Yes ☐ No
If Yes, please explain:_____
_____
_____

Consent – To the best of knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice.
I understand there are no guarantees or warranties in health or dental care.

Patient or Responsible Party Signature_____ **Date**_____