

DESTINATIONDENTAL

Name:	☐ Name Change	DOB:
☐ Change of Address, Phone, Status or insurance	☐ No Change	Primary Care Physician:
New address: _____		
New Phone Number: (____) _____		Dentist:
Change in Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		

INSURANCE INFORMATION & MEDICAL HISTORY UPDATE FORM

PRIMARY INSURANCE INFORMATION ☐ New ☐ Additional ☐ Change of Information	
DO YOU HAVE MEDICAL COVERAGE? ☐ Yes ☐ No	DO YOU HAVE DENTAL BENEFITS? ☐ Yes ☐ No

PRIMARY MEDICAL	Name of insured: _____	PRIMARY DENTAL BENEFIT	Name of insured: _____
	Date of birth: _____		Date of birth: _____
	Relationship to patient: _____		Relationship to patient: _____
	Insured's employer: _____		Insured's employer: _____
	Insurance company name: _____		Insurance company name: _____
	Insurance ID#: _____		Insurance ID#: _____
	Group number: _____		Group number: _____
	Insurance address: _____		Insurance address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____		
Insurance phone#: _____	Insurance phone#: _____		
If Union, Local#: _____	If Union, Local#: _____		

SECONDARY INSURANCE INFORMATION ☐ New ☐ Additional ☐ Change of Information
--

SECONDARY MEDICAL	Name of insured: _____	SECONDARY DENTAL BENEFIT	Name of insured: _____
	Date of birth: _____		Date of birth: _____
	Relationship to patient: _____		Relationship to patient: _____
	Insured's employer: _____		Insured's employer: _____
	Insurance company name: _____		Insurance company name: _____
	Insurance ID#: _____		Insurance ID#: _____
	Group number: _____		Group number: _____
	Insurance address: _____		Insurance address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____		
Insurance phone#: _____	Insurance phone#: _____		
If Union, Local#: _____	If Union, Local#: _____		

YES	NO	PLEASE UPDATE PATIENT HEALTH HISTORY
------------	-----------	---

☐	☐ Are there any recent changes in your medical condition or overall health?	If yes, please explain: _____
☐	☐ Have you had any recent surgeries?	If yes, please explain: _____
☐	☐ Have you had any recent traumas?	If yes, please explain: _____
☐	☐ Are you currently taking any medication?	If yes, please list medications:
	<i>Name</i>	<i>Dose</i>
	_____	_____
	_____	_____
☐	☐ Do you have any new allergies since your last visit?	If yes, please list allergies:
	<i>Type</i>	<i>Reaction (rash/hives/airway)</i>
	_____	_____
☐	☐ Do you suffer from any chronic illnesses such as:	☐ Asthma ☐ Diabetes ☐ Thyroid Disease
	If yes, please explain: _____	☐ Heart Disease ☐ Other: _____

Patient Signature:	Date:	Witness:	Doctor:
--------------------	-------	----------	---------