DESTINATIONDENTAL

Name: ☐ **Name Change** **DOB:**

☐ **Change of Address, Phone, Status or insurance** ☐ **No Change**
New address: _____
New Phone Number: ( ) _____
Change in Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary Care Physician:

Dentist:

INSURANCE INFORMATION & MEDICAL HISTORY UPDATE FORM

PRIMARY INSURANCE INFORMATION ■ **New** ■ **Additional** ■ **Change of Information**

DO YOU HAVE MEDICAL COVERAGE? ☐Yes ☐No

PRIMARY MEDICAL

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

DO YOU HAVE DENTAL BENEFITS? ☐Yes ☐No

PRIMARY DENTAL BENEFITS

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

SECONDARY INSURANCE INFORMATION ■ **New** ■ **Additional** ■ **Change of Information**

SECONDARY MEDICAL

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

SECONDARY DENTAL BENEFITS

Name of insured: _____
Date of birth: _____
Relationship to patient: _____
Insured's employer: _____
Insurance company name: _____
Insurance ID#: _____
Group number: _____
Insurance address: _____
City: _____ State: Zip:
Insurance phone#: _____
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 currenty taking any medication?** If yes, please list medications:

Name	***Dose***	***Frequency***

☐ ☐ **Do you have any new allergies since your last visit?** If yes, please list allergies:

Type	***Reaction*** *(rash/hives/airway)*	***Duration***

☐ ☐ **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:**