FORT LORAMIE
DENTAL CENTER Family Dentistry, Orthodontics, & Dental Implants

Christopher M. Ashby, D.D.S.

In order for our office to provide you better quality care and service, we require this form to be updated yearly.

PATIENT NAME _____ **DATE** _____

Social Security # _____ Date of Birth _____

Address _____ Employer _____

_____ _____

Home Phone # _____ Cell Phone # _____

Work Phone # _____ E-mail Address _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

Social Security # _____ Date of Birth _____

Address _____ Phone # _____ Employer _____

Address _____ Work # _____ _____

DENTAL INSURANCE _____ Yes _____ No

	Primary	Secondary
Subscriber Name	_____	_____
Insurance Company	_____	_____

** In order for us to submit your claim to your insurance you must provide us with the name and address of your carrier, we will gladly make a copy of your insurance card if you have one.

MEDICAL HISTORY UPDATE

Have you been under a physician's care or hospitalized in the last 12 months?	YES	NO
If yes, reason? _____		
Are you taking any medications, prescription or non prescription?	YES	NO
If yes, please list _____		
Have you ever had heart problems/surgery, heart murmur, mitral valve prolapse, or a pace maker? (specify) _____	YES	NO
Have you ever had an artificial joint replacement? Any surgeries requiring metal pins, plates, or screws? If so, when? _____	YES	NO
Women, are you currently pregnant?	YES	NO

Please list allergies to medications and general allergies: _____

Circle any of the following that apply to you now or in the past:

Asthma	Diabetes	High Blood Pressure	Lung/Breathing Problems
Blood Disorders	Epilepsy/Seizures/Fainting	HIV(AIDS)	Sinus Trouble
Cancer	Heart Problems	Liver/Kidney Disease	Stroke
Circulation Problems	Hepatitis	Low Blood Pressure	

Other Serious Illness _____

Signature _____ Date _____

Notes:

Signature _____ Comments _____ Date _____

Signature _____ Comments _____ Date _____

Signature _____ Comments _____ Date _____