Patient Update Form | David Lester, DDS

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Best Phone Number to Reach You: _____

Email: _____

How would you prefer we contact you to confirm your appointments?: CALL TEXT EMAIL

Emergency Contact (Name & Phone number): _____

DISCLOSURE

David Lester, DDS has my authorization to disclose my Medical and Insurance information to the following person(s):

Name(s): _____

Phone: (_____) _____ E-Mail: _____

HAVE YOU HAD ANY CHANGES IN YOUR DENTAL INSURANCE SINCE YOUR PREVIOUS VISIT?

(Circle one) Yes / No

MEDICAL INFORMATION

Physician's Name: _____

Physician's Phone Number: _____

Have you been admitted to the hospital in the last three years? _____

If so, for what reason? _____

Please list any medications you are currently taking: _____

_____

Please circle any medications to which you are allergic:

PENICILLIN CODEINE ASPIRIN LIDOCAINE CARBOCAINE

OTHER:_____

Have you ever had any excessive bleeding that needed special treatment? YES / NO

If yes, please explain: _____

Are you currently taking blood thinners: YES / NO

Please circle ANY that you *may* have or *have* had:

Anemia	Rheumatic Fever	Muscle Problems	Allergies
Epilepsy	Tumor	Kidney Trouble	Heart Troubles
Low Blood Pressure	High Blood Pressure	HIV Positive	Arthritis
Hypoglycemia	Sinus Problems	Tuberculosis	Diabetes
Radiation Therapy	Hepatitis	Drug Addiction	Asthma
Stroke	Fainting Spells	Skin Problems	Liver Disease

CONSENT FOR TREATMENT:

I understand that it is the responsibility of the patient to inform Dr. Lester of any changes in their health. I, the undersigned (or legally responsible party), authorize and request the performance of dental services on myself (or the above named individual) and, further the performance of any operation rendered by the dentist and his staff. I also authorize the administration of such anesthetics or analgesics, local or inhalation, which the doctor may deem advisable. Furthermore, I will be responsible for any financial obligations incurred for dental treatment upon myself (or the above name patient). I understand that the charges are my personal responsibility regardless of insurance benefits.

Signature: _____ Date: _____

NAME & LOCATION OF PHARMACY FOR PRESCRIPTIONS: _____