Dr. David Roach, D.D.S.

PATIENT UPDATE FORM

(Please Print)

Today's Date:	Patient #:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Street address:	Cell phone no.: ( )	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Email:	Preferred method of contact: ☐ Email ☐ Cell Phone ☐ Home Phone ☐ Work Phone	Work phone no.: ( )

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last appointment? ☐ Yes ☐ No

If yes, please explain:

Are you taking any kind of medication at this time? ☐ Yes ☐ No

If yes, please explain:

Do you have any allergies to medications? ☐ Yes ☐ No

If yes, please list them:

Have you been hospitalized within the past few years? ☐ Yes ☐ No

If yes, please explain:

Women: Are you pregnant? ☐ Yes ☐ No

Due Date:

INSURANCE INFORMATION

Subscriber Name:	Subscriber DOB:	Subscriber SS#:	Subscriber Employer:

Relationship to Patient:	Insurance Co:	ID# on Ins. Card:	Group #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. David Roach to release any information required to process my claims.

Patient/Guardian Signature _____ Date _____