solstice DENTISTRY

Ben Belfiglio, DDS

Debbie Wrigley, DDS

UPDATE FORM

Patient Name (Legal as on Insurance): _____

Preferred Name/ Nickname: _____ Date of Birth: _____

Address: _____ Phone: _____

E-mail Address: _____ Insurance: _____

Are you ALLERGIC or had an unfavorable reaction to the following:

❑ Penicillin ❑ Clindamycin ❑ Other drugs:_____

❑ Novocaine or other local anesthetics _____ ❑ Latex ❑ Metal _____

Do you or have you had any of the following: (Please describe Yes responses in Comments Below)

❑ Anemia	❑ Any Surgeries	❑ Arthritis	❑ Artificial Joints
❑ Asthma	❑ Autoimmune	❑ Blood Disease	❑ Cancer – List Type
❑ Chemical Dependency	❑ Diabetes	❑ Dizzy/Fainting	❑ Dry Mouth
❑ Epilepsy	❑ Excessive Bleeding	❑ Gastric Reflux	❑ Glaucoma
❑ Hay Fever/Allergies	❑ Head Injuries	❑ Heart Attack	❑ Heart Disease/Defect
❑ Heart Murmur	❑ Heart Surgery/Valves	❑ Hepatitis/Jaundice	❑ High Blood Pressure
❑ Kidney Disease	❑ Liver Disease	❑ Mental Disorders	❑ Nervous Disorders
❑ Pacemaker	❑ Radiation/ Chemo	❑ Need Wheelchair	❑ Respiratory Problems
❑ Rheumatic Fever	❑ Rheumatoid Arthritis	❑ Sinus Problems	❑ Stomach Problems
❑ Stroke	❑ Tuberculosis	❑ Tumors	❑ Ulcers

Comments or anything else we should be aware of: _____

_____

Are you pregnant? If yes, when are you due? _____

Please list any medications you are currently taking: _____

_____

Signature: _____ Date: _____