new smiles studio
melanie marshall, dds

Patient Information Update

Today's Date_____

Patient Name: First_____ MI_____ Last_____ Nickname_____

Phone: Home_____ Work_____ Mobile_____

Email address:_____

New Address: Street_____ City_____ State_____ Zip_____

Have there been any changes to your Dental Benefit Plan Information? **Yes** **No**

Primary Dental Plan Name_____ Phone_____

Name of Insured_____ Date of Birth_____ ID number_____

Policy number_____ Patient relationship to insured_____

Have you had a change in your health since your last visit? Yes No

Please review your previous health history and list changes:

1. _____
2. _____
3. _____

Have you had a visit to a physician or a hospital since your last visit? Yes No

Please explain:

_____

_____

Please list any medications, vitamins or herbal supplements you are taking, and for what purpose:

Medication or Supplement	Reason You Are Taking It

Date: _____ **Signature: _____**