Patient Information Update

Date:_____ Name:_____ Birth Date:_____
Home phone #:_____ Cell phone #:_____
Please list below if there as been any changes in your address, insurance or employment since your last visit. _____

Medical History Update

Physician's Name:_____ Date of last visit_____
Phone:_____ Pharmacy:_____ Phone:_____
Please list all medications you are currently taking:_____
_____

Please check "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV positive	□Yes □No	Hepatitis Type __	□Yes □No
Anemia	□Yes □No	High/Low Blood Pressure	□Yes □No
Arthritis, Rheumatism	□Yes □No	Jaw Pain	□Yes □No
Artificial Heart Valves	□Yes □No	Joint Replacement	□Yes □No
Back Problems	□Yes □No	Mitral Valve Prolapse	□Yes □No
Cancer	□Yes □No	Pacemaker	□Yes □No
Cortisone Treatments	□Yes □No	Psychiatric Care	□Yes □No
Cough, persistent or bloody	□Yes □No	Sinus Trouble	□Yes □No
Diabetes Type __	□Yes □No	Stroke	□Yes □No
Emphysema	□Yes □No	Thyroid Problems	□Yes □No
Epilepsy	□Yes □No	Tonsillitis	□Yes □No
Heart Problems	□Yes □No	Tuberculosis	□Yes □No

Are you taking or have previously taken these medications?
Blood thinners such as Coumadin or Plavix?
□ Yes □ No
Bisphosphonates such as Fosamax, Actonel or Boniva?
□Yes □ No

Are you allergic to:			
Aspirin	□Yes □No	Penicillin	□ Yes □ No
Barbiturates	□Yes □No	Sulfa	□ Yes □ No
Codeine	□Yes □No		
Iodine	□Yes □No	**Women:**	
Latex	□Yes □No	Are you pregnant?	□Yes □No
Local Anesthesia	□Yes □No	Are you nursing?	□Yes □No
		Are you taking Birth Control Pills?	□Yes □No

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.
I certify that I, and/or my dependant(s), have insurance coverage and assign directly to Dr. Olivero all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature of Patient, Parent or Guardian **Date**