



Darren M. Chugg, D.M.D. 7545 W. Bell Road, Suite 105 Peoria, Arizona 85382 (623) 487-1122

ESTABLISHED PATIENT: DENTAL & MEDICAL HISTORY UPDATE

To ensure the highest quality of healthcare, we ask that you complete this patient update form.

Today's Date: _____/_____/_____ Social Security Number: _____

Patient Name: _____ Date of Birth: ____/____/_____

Reason for Today's Visit: _____

Contact Information

Address: _____ City _____ State _____ Zipcode _____

Best Phone Number: () _____ Email Address: _____

Preferred Method of Contact: Home Phone Cell Phone Email

Emergency Contact Name: _____ Relationship: _____ Phone: () _____

	NO	YES	IF YES, PLEASE EXPLAIN
Any changes in dental insurance?			If yes, please complete reverse side of form.
Any change in health since last dental visit?			
Any surgeries or hospitalizations since last dental visit?			
Any changes in dental health since last visit?			
Have you been vaccinated for COVID-19?			
Any new family history of cancer or other health issues?			
Are you taking any new medications or supplements (prescription and/or non-prescription)?			
Are you allergic to any medications, foods, or latex?			
Do you use any tobacco products?			
<i>Females only:</i> Are you pregnant or nursing?			
<i>Females only:</i> Are you taking birth control?			

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 dependent(s) have insurance coverage with _____ and assign directly to Dr. Darren Chugg 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.

The above named dentist may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance



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benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Patient/Parent Signature: _____ **Date:** ____/____/____

UPDATED DENTAL INSURANCE INFORMATION

Name of Insured: _____ Relation to Patient: _____

Date of Birth: ____/____/____ Social Security Number: ____-____-____

Address: _____ City _____ State ____ Zipcode _____

Home Phone Number: () _____ Cell Phone Number: () _____

Email Address: _____ @ _____ Preferred Method of Contact: Home Cell Email

Insurance Company: _____ Insurance Phone: () _____

Insurance Address: _____ City _____ State ____ Zipcode: _____

Employer: _____ Subscriber ID Number: _____ Group Number: _____

Secondary Dental Insurance: Yes No If yes, complete:

Employer: _____ Subscriber ID Number: _____ Group Number: _____

Name of Insured: _____ Relation to Patient: _____

Insurance Company: _____ Insurance Phone: () _____

Insurance Address: _____ City _____ State ____ Zipcode: _____