Darren M. Chugg, D.M.D. 6120 W. Bell Road, Suite 170 Glendale, Arizona 85308 (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: ________/_________/____________

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 the reverse side of this form.**
Any change in general or dental health since last dental visit?			
Any surgeries or hospitalizations since your last dental visit?			
Do you have any joint replacements / heart issues			
Any new family history of cancer or other health issues?			
Are you taking any new medications or supplements (prescription and/or non-prescription)?			**If yes, please list them out on the reverse side of this form.**
Do you need to be premedicated?			
Are you allergic to any medications, foods, or latex?			
Are you on any blood thinners			
Do you use any tobacco products?			
Females only: Are you pregnant or nursing?			
Females only: Are you taking birth control?			

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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 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: _________

<u>Please list CURRENT /NEW medications below:</u>

1.____________________________________ **6.**____________________________________

2.____________________________________ **7.**____________________________________

3.____________________________________ **8.**____________________________________

4.____________________________________ **9.**____________________________________

5.____________________________________ **10.**__________________________________