

Welcome

Thank you for selecting Houma Family Dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form. If you have any questions, please ask us – we will be happy to help!



5683 Hwy 311 (985) 868-5699

Patient Update Form

Name _____ SS# _____ DOB _____
Last First Middle

Mailing Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Email _____ Primary Language _____ Gender Male Female

Check Appropriate Box: Minor Married Single Divorced Widowed Separated

Emergency Contact Name _____ Phone: _____

Person Responsible (Insured) for this Account _____ Relationship to Patient _____

**Please provide the insurance card.

PLEASE CHECK YES OR NO TO EACH.

	YES	NO		YES	NO
Are you under medical treatment now?	_____	_____	Are you allergic to or have any reactions to the following?	_____	_____
Have you ever been hospitalized for any surgical operation or serious illness?	_____	_____	Local anesthetics (Novocain, etc.)	_____	_____
If yes, explain: _____			Penicillin or other antibiotics	_____	_____
Are you taking any medications including non-prescription?	_____	_____	Sulfa drugs	_____	_____
If yes, list: _____			Barbiturates	_____	_____
Have you ever taken Phen-Fen/Redux?	_____	_____	Sedatives	_____	_____
Do you use controlled substances?	_____	_____	Iodine	_____	_____
Are you wearing contact lenses?	_____	_____	Aspirin	_____	_____
Do you use tobacco?	_____	_____	Any metals	_____	_____
			Latex rubber	_____	_____
WOMEN ONLY:			Other, please list: _____		
Are you pregnant or think you may be?	_____	_____	Do you have or have had asthma?	_____	_____
Are you nursing?	_____	_____	If yes, date of last attack _____		
Are you taking oral contraceptives?	_____	_____			

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING? PLEASE CIRCLE ALL THAT APPLY.

Anemia	Epilepsy/Convulsions	Hepatitis	Low Blood Pressure	Sexually Transmitted Disease
Angina	Fainting/Seizures	High Blood Pressure	Mitral Valve Prolapse	Stomach Troubles/Ulcers
Arthritis	Frequently Tired	HIV/AIDS infection	Pacemaker	Stroke
Asthma	Glaucoma	Jaundice	Physical/Mental Disability	Swollen Ankles
Cancer	Heart attack	Joint Replacement/Implant	Radiation Treatment	Thyroid Problems
Chest pains	Heart disease	Kidney Disease	Recent Weight Loss	Tuberculosis
Diabetes	Heart murmur	Leukemia	Respiratory Problems	Other: _____
Emphysema	Heart trouble	Liver Disease	Rheumatic Fever	_____

Signature _____ Date _____