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!

HOUMA FAMILY DENTAL

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

Name of Person Responsible (Insured) for this Account _____ Relationship to Patient _____
**Please provide the insurance card.

PLEASE CHECK YES OR NO TO EACH.	YES	NO
Are you under medical treatment now?		
Have you ever been hospitalized for any surgical operation or serious illness?		
If yes, explain: _____		
Are you taking any medications including non-prescription?		
If yes, list: _____		
Have you ever taken Phen-Fen/Redux?		
Do you use controlled substances?		
Are you wearing contact lenses?		
Do you use tobacco?		
WOMEN ONLY:		
Are you pregnant or think you may be?		
Are you nursing?		
Are you taking oral contraceptives?		

	YES	NO
Are you allergic to or have any reactions to the following?		
Local anesthetics (Novocain, etc.)		
Penicillin or other antibiotics		
Sulfa drugs		
Barbiturates		
Sedatives		
Iodine		
Aspirin		
Any metals		
Latex rubber		
Other, please list: _____		
Do you have or have had asthma?		
If yes, date of last attack _____		

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 _____