# 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

Emergency Contact Name _____ Phone: _____

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

Name of Primary Insurance _____ Name of Secondary Insurance_____

| **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 _____