STEWART M. SHEINBEIN, D.D.S.

Patient Information Update

Name____________________ Home Phone________________ Age________

Address____________________ City________________ State________ Zip________

Work Phone____________________ Email ____________________

Insurance Information Update

Insurance Company ____________________ Group # ____________________

Medical History Update

	Yes	No
1. Are you taking any medications? If yes, what medications? ____________________	____	____
2. Are you allergic to any medications? If yes, what medications ____________________	____	____
3. Women, Are you pregnant?	____	____

4. Do you have or have you had any of the following?

	Yes	No		Yes	No
High Blood Pressure	____	____	Cancer	____	____
Heart Disease	____	____	Joint Replacement	____	____
Fainting/Seizures	____	____	Hepatitis	____	____
Diabetes	____	____	Ulcers	____	____
Kidney Disease	____	____	Stroke	____	____
AIDS or HIV infection	____	____	Tuberculosis	____	____
Thyroid Problem	____	____	Liver Disease	____	____
Heart Murmur	____	____	Other	____	____
Respiratory Problems	____	____			

X____

Signature of patient or parent if minor Date

X____

Doctor's Signature Date