Calvin R White Jr DDS PC
4101 Route 17
Yorktown, VA 23692
calvinwhitedds@gmail.com
757-898-7200

Patient Update

Date:_____
SSN:_____

Patient Information (CONFIDENTIAL) *Please circle: Male / Female*
Name:_____Birthdate:_____Home Phone:_____
Address:_____City:_____State_____Zip_____
Email:_____Cell Phone:_____
I would like to receive office info/appointment reminders via: ☐email ☐text ☐phone call (Circle all that apply)
Please check one: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient or Parent/Guardian's Employer_____Work Phone:_____
Who may we thank for referring you?_____
Emergency Contact:_____Phone:_____ Relationship to Patient:_____

Responsible Party *Relationship*
Name of Person Responsible for this account:_____to Patient:_____
Address:_____City:_____State:_____Zip_____
Birthdate:_____SSN:_____Home Phone:_____
Email:_____Cell Phone_____
Is this person an active patient in this office? ☐ Yes ☐ No Please review financial policy and sign. Thank you

Insurance Information if it has changed *Relationship*
Name of Policy Holder:_____ to Patient_____
Policy Holder Birthdate_____SSN:_____
DENTAL Insurance Company_____ Policy ID#_____
Ins. Co. Address_____ City_____ State:_____ Zip_____
Policy Holder's Employer_____Phone_____
Employer Address_____ City_____ State:_____ Zip_____

Patient Medical History
Physician_____ Office Phone_____Date of Last Exam_____

1. *Are you under medical treatment now?.... ☐ Yes ☐ No*
2. *Have you been hospitalized for any surgical operation Or serious illness in the last 5 years? .. ☐ Yes ☐ No*

Please Explain_____
_____
_____

3. *Are you taking any medications including non-Prescription meds?..... ☐ Yes ☐ No*
   List meds_____

_____
_____

4. *Have you ever taken Fosamax, Boniva, Actonel or any other Cancer medications containing bisphosphonates? ☐ Yes ☐ No*

5. *Have you ever had a serious head, neck, or back injury? ..... ☐ Yes ☐ No*

Please Explain:_____

6. *Are you allergic or have you had reactions to any of the following?*

Local Anesthetics(Ex Novocain)..... ☐ Yes ☐ No
Penicillin or any other antibiotics ... ☐ Yes ☐ No
Sulfa Drugs..... ☐ Yes ☐ No
Barbiturates ..... ☐ Yes ☐ No
Sedatives..... ☐ Yes ☐ No
Iodine..... ☐ Yes ☐ No
Aspirin ..... ☐ Yes ☐ No
Any Metals(nickel,mercury,etc.).. ☐ Yes ☐ No
Latex Rubber..... ☐ Yes ☐ No
Other_____

Please continue to the next page.

7. Do you use tobacco?.. ☐*Yes* ☐*No*

8. Do you have a persistant cough or throat clearing not associated with a known illness?(Lasting more than 3 weeks?)..... ☐*Yes* ☐*No*

9. Have you had a joint replacement? If yes, Date:_____
Does this require a PRE-MED?..... ☐ *Yes* ☐ *No*
If yes, pre-med you take:_____

10. Are you taking blood thinners? ☐*Yes* ☐ *No*

11. Women ONLY:
A) Are you pregnant ?..... ☐ *Yes* ☐ *No*
B) Are you nursing?..... ☐ *Yes* ☐ *No*
C) Are you taking oral contraceptives? ☐ *Yes* ☐*No*

Have you ever had or do you have any of the following? ***PLEASE CIRCLE YES OR NO***

High Blood Pressure…	*Yes*	*No*	*Heart Disease……*	*Yes*	*No*	*Chest Pains ……*	*Yes*	*No*
Heart Attack/Failure ….	*Yes*	*No*	*Heart Pacemaker….*	*Yes*	*No*	*Bruise Easily ……..*	*Yes*	*No*
Rheumatic Fever…….	*Yes*	*No*	*Heart Murmur……..*	*Yes*	*No*	*Stroke……*	*Yes*	*No*
Swelling of limbs……	*Yes*	*No*	*Anemia……..*	*Yes*	*No*	*Tuberculosis……..*	*Yes*	*No*
Asthma……	*Yes*	*No*	*Emphysema ……*	*Yes*	*No*	*Radiation Therapy..*	*Yes*	*No*
Low Blood Pressure……	*Yes*	*No*	*Cancer……*	*Yes*	*No*	*Chemotheraphy…….*	*Yes*	*No*
Epilepsy/Convulsions…	*Yes*	*No*	*Angina……..*	*Yes*	*No*	*Glaucoma ……*	*Yes*	*No*
Leukemia……..	*Yes*	*No*	*Hepatitis/jaundice*	*Yes*	*No*	*Stomach ulcers……*	*Yes*	*No*
Diabetes……	*Yes*	*No*	*Liver Disease……*	*Yes*	*No*	*Thyroid Disease…..*	*Yes*	*No*
High Cholesterol ……	*Yes*	*No*	*Osteoporosis……*	*Yes*	*No*	*Psychiatric Care……*	*Yes*	*No*
Kidney Disease……	*Yes*	*No*	*Tumors or growths..*	*Yes*	*No*	*Blood Transfusion….*	*Yes*	*No*
Recent Weight Loss…..	*Yes*	*No*	*Lung Disease……..*	*Yes*	*No*	*Blood disease…….*	*Yes*	*No*
Arthritis ……..	*Yes*	*No*	*Hypoglycemia……..*	*Yes*	*No*	*Excessive Bleeding….*	*Yes*	*No*
Sickle Cell Disease …….	*Yes*	*No*	*Breathing Problem*	*Yes*	*No*	*Cold Sores/Fever Blisters*	*Yes*	*No*
AIDS or HIV infection….	*Yes*	*No*	*Other:_____*					

Authorization and Release

I certify that I have read and understand the above to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health or my dependent's health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date:_____
Responsible Party (Please Print)

X_____ Date:_____
Responsible Party Signature

As always, we thank you for your patronage and support of our dental practice.
Dr. Calvin R. White Jr. D.D.S. PC