KURT C. LAUNEY. DDS

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WELCOME BACK

Welcome back to our office. Please update the following form. We understand that completing this form can be time consuming, but our goal is to provide you with the best possible care that we can. Updating this form will aid us in achieving this goal! Thank you!

PATIENT INFORMATION

FIRST NAME:	MIDDLE:	LAST:	DOB:
ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE:	WORK PHONE:	CELL PHONE:	
RESPONSIBLE PARTY:	SS#:	EMAIL	

INSURANCE INFORMATION

INSURED NAME:	SS#:		DOB:
EMPLOYER:		INSURANCE COMPANY:	
INSURANCE PHONE:		GROUP NUMBER:	
INSURANCE ADDRESS:	CITY:	STATE:	ZIP:

MEDICAL HISTORY INFORMATION

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING? PLEASE CIRCLE YES OR NO

YES / NO	ANEMIA	YES / NO	HEART MURMUR	YES / NO	MITRAL VALVE PROLAPSE
YES / NO	ARTIFICIAL VALVES	YES / NO	HEPATITIS	YES / NO	RHEUMATIC FEVER
YES / NO	ASTHMA	YES / NO	HIGH BLOOD PRESSURE	YES / NO	SCARLET FEVER
YES / NO	BLADDER DISEASE	YES / NO	HIV / AIDS	YES / NO	STROKE
YES / NO	DIABETES	YES / NO	JOINT REPLACEMENT	YES / NO	THYROID DISEASE
YES / NO	EPILEPSY / SEIZURES	YES / NO	KIDNEY DISEASE	YES / NO	TUBERCULOUS
YES / NO	HEART DISEASE	YES / NO	LOW BLOOD PRESSURE	OTHER:	

PLEASE LIST ANY MEDICATION YOU ARE CURRENTLY TAKING:

DO YOU HAVE ALLERGIES TO THE FOLLOWING? PLEASE CIRCLE YES OR NO

YES / NO	CODEINE	YES / NO	LATEX	YES / NO	PENICILLIN
YES / NO	IODINE	YES / NO	LOCAL ANESTHESIA	YES / NO	SULFA DRUGS
YES / NO	RECREATIONAL DRUGS	OTHER:			

YES / NO	HAVE YOU EVER BEEN TREATED FOR CHEMICAL DEPENDENCY?	YES / NO	HAVE YOU EVER BEEN HOSPITALIZED? PLEASE EXPLAIN

NOTICE: PAYMENT IS EXPECTED AT THE TIME OF YOUR APPOINTMENT, INCLUDING THE PATIENT ESTIMATED PORTION.

PATIENT OR RESPONSIBLE PARTY SIGNATURE:	DATE: