PATIENT UPDATE INFORMATION

In order for us to better serve you, please fill in the following information completely to update your records.

Patient's Name____

Current Street Address______________________________________

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Home Phone ________________ Cell Phone ________________

Work Phone__________________ Other____________________

Place of Employment____

Emergency
Contact________________Relation_______________Phone__________

List <u>all</u> medications(USE BACK IF NECESSARY)________________________

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INITIAL ONE (1)

____ I accept dilation ____ I decline dilation

_____ I would like to reschedule dilation

INITIAL ONE (1) <u>The fee for this extended test is $18.00</u>

____ I accept photography ____I decline photography

INITIAL ONE (1) <u>The fee for this extended test is $18.00</u>

____I accept the GDX ____I decline the GDX

Patient Signature_____________________________ Date___________