



Dr. Luciana Rausch, D.M.D.
 1336 West Main St, Suite 2B
 Waterbury, CT 06708
 Telephone: (203) 754-4175

UPDATE FORM FOR CURRENT PATIENTS

NAME _____ DATE OF BIRTH _____
 ADDRESS _____ CITY, STATE, ZIP CODE _____
 CELL # _____ HOME # _____ WORK # _____
 EMAIL _____
 EMERGENCY CONTACT AND MOBILE # _____

PLEASE, LIST ALL MEDICATIONS AND SUPPLEMENTS CURRENTLY TAKING:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

PLEASE, LIST ANY ALLERGIES TO MEDICATION:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

DID YOUR DENTAL INSURANCE CHANGE? YES _____ NO _____

IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

INSURANCE COMPANY _____ ID # _____ GROUP # _____
 POLICY HOLDER NAME _____ DOB _____ SSN _____

CANCELLATION POLICY: We require a 24hr notice for any cancelled appointment. Any missed appointment will be charged a fee based on length of appointment.

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries above have been answered to my satisfaction. I will not hold my doctor, or any other member of her staff, responsible for any errors or omissions that I have made in the completion of this form.

SIGNATURE _____ DATE _____