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## CHANGES TO PATIENT'S RECORDS

Please let us know if there have been any changes to the following since your last visit:

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

(PLEASE PROVIDE THE E-MAIL ADDRESS YOU CHECK MOST FREQUENTLY)

\* We use e-mail addresses as a way to confirm appointments. If you do not check your e-mail frequently, please write DO NOT USE and we will attempt to reach you by telephone.

DENTAL INSURANCE: \_\_\_\_\_

GROUP/POLICY NUMBER: \_\_\_\_\_

INSURANCE CO. PHONE NUMBER: \_\_\_\_\_

EMPLOYEE INS. ID#: \_\_\_\_\_

ANY CHANGES IN YOUR HEALTH, INCLUDING MEDICATIONS,  
PLEASE COMPLETE A NEW HEALTH HISTORY.

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

(PLEASE PRINT)

SIGNATURE: \_\_\_\_\_