

Patient Update

Please fill in all the information, so that we may accurately update your history. Thank you!

PATIENT'S NAME _____ BIRTHDAY ____/____/____ AGE _____

ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP _____ CELL PHONE _____

EMPLOYER/OCCUPATION _____ WORK PHONE _____

DENTAL INSURANCE PLAN (if any) _____

DENTAL HISTORY

WHAT CONCERNS YOU ABOUT YOUR TEETH? _____

MEDICAL HISTORY

PHYSICIAN'S NAME _____ PHONE _____ DATE OF LAST VISIT _____

ARE YOU PRESENTLY UNDER A PHYSICIAN'S CARE? _____ Yes _____ No

If YES, please explain _____

HAVE YOU EVER HAD A SERIOUS ILLNESS/ OPERATION, OR STILL HAVE ONE? _____ Yes _____ No

If YES, please explain _____

ARE YOU TAKING ANY MEDICATIONS OR SUPPLEMENTS? _____ Yes _____ No

If YES, please list _____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS OR DRUGS? _____ Yes _____ No If YES, list: _____

HAVE YOU EVER TAKEN BONE DRUGS? (Fosamax, Evista, Actonel, Boniva, Reclast, others) _____ Yes _____ No

CHECK ANY THAT APPLY: _____ Allergies to Anesthetics _____ Artificial Joints _____ Artificial Heart Valve _____ Hepatitis

_____ High Blood Pressure _____ Cancer _____ Heart Problems _____ Liver or Kidney Problems _____ Tobacco Use _____ Tuberculosis

_____ Immune Problems _____ Bleeding Problems _____ HIV Positive _____ Taking Contraceptives _____ Latex Allergy _____ Diabetes

_____ Now Pregnant _____ Psychiatric or Emotional Problems _____ Other, please explain _____

We do appreciate the referral of your friends and family!