MEDICAL HISTORY UPDATE

DEAR PATIENTS,
THANK YOU FOR TAKING THE TIME TO HELP US UPDATE OUR RECORDS. AS ALWAYS, WE APPRECIATE THE OPPORTUNITY TO CONTINUE PROVIDING YOU WITH DENTAL TREATMENT. THANK YOU FOR CHOOSING US!

NAME__________________________ BIRTHDATE __________________DATE__________________

HAVE YOU HAD AN ADDRESS CHANGE?

____

HM PHONE______________CELL PHONE ________________ WK PHONE____________________

EMERGENCY CONTACT PERSON ____

RELATIONSHIP _______________________________ PHONE NUMBER____________________

HAVE YOU HAD ANY DENTAL INSURANCE CHANGES? __________________________________

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING

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PLEASE CIRCLE ANY MEDICAL CONDITIONS THAT YOU HAVE HAD:

HEART ATTACK HEART MURMUR RHEUMATIC FEVER MITRAL VALVE PROLAPSE

HEART SURGERY HIGH BLOOD PRESSURE STROKE CHEMOTHERAPY

HIV/AIDS DRUG/ALCOHOL ABUSE CANCER DIABETES KIDNEY DISEASE

TUBERCULOSIS EPILEPSY/SEIZURES PSYCHIATRIC DISORDERS HEMOPHILLA

SINUS PROBLEMS HEPATITIS HIP/KNEE REPLACEMENT- SURGERY DATE ( )

HAVE YOU BEEN TOLD BY A PHYSICIAN THAT YOU REQUIRE PREMEDICATION FOR HEART PROBLEMS, RHEUMATIC FEVER, OR JOINT REPLACEMENT? ___YES___NO

PLEASE CIRCLE ANY ALLERGIES:

LATEX ERYTHROMYCIN PENICILLIN DENTAL ANESTHETICS ASPIRIN

CODEINE SULFA TETRACYCLINE OTHERS__________________________

ARE THERE SPECIFIC DENTAL CONCERNS THAT WE SHOULD KNOW ABOUT TODAY?
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FOR WOMEN: ARE YOU PREGNANT?_____________________

I UNDERSTAND THAT THE INFORMATION CONCERNING MY MEDICAL HISTORY WILL BE HELD BY THIS OFFICE IN THE STRICTEST CONFIDENCE, AND WILL NOT BE SHARED WITH ANYONE OUTSIDE THIS OFFICE OTHER THAN PROFESSIONALS TO WHOM I AM REFERRED AS PART OF MY TREATMENT. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR FOR MY DEPENDENTS. ALSO, I AUTHORIZE USE OF MY INSURANCE FOR ALL SUBMISSIONS AND PERMIT THIS SIGNATURE TO BE USED FOR ALLOWING INSURANCE PAYMENTS TO BE SENT DIRECTLY TO THIS OFFICE FOR REIMBURSEMENT OF SERVICES RENDERED ON MY BEHALF.

SIGNATURE_________________________________