Medical History Update

NAME______________________________ Date of Birth ________________________________

Cell #__________________________Home #________________________EMAIL_____________________________________

Emergency Contact ____________________________ Phone #____________________ Relationship to Patient_____________

Are you under medical treatment now? If so Physician ______________________Office #________________Last Exam_______

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? __________________________

Do you have any allergies to Medications/Antibiotics/Sulfa Drugs/Local Anesthetics/Seasonal/Latex? ______________________

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Are you taking any medication(s) including non-prescription? ____

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Do you have or have you had any of the following? Check YES or NO

	Yes	No		Yes	No		Yes	No
High Blood Pressure			Nervous Disorder			Artificial Joint		
Low Blood Pressure			Hemorrhagic Stroke			Revised Artificial Joint		
Heart Disease			Liver Disease			Artificial Heart Valve		
Chest Pains			Hepatitis/Jaundice			Mitral Valve Prolapse		
Stroke			AIDS or HIV			Endocarditis		
Angina			Blood Disease			Smoke/Chewing Tobacco		
Heart Attack			Excessive Bleeding			Emphysema		
Pacemaker			Anemia			Respiratory Problems		
Heart Murmur			Stomach/Ulcers			Asthma		
Rheumatic Fever			Sinus Problems			Tuberculosis		
Epilepsy/Seizures			Cancer			Arthritis		
Fainting/Dizziness			Radiation			Osteoporosis		
Diabetes			Chemo			Taken Bone Density Meds		
Swollen Ankles			Dry mouth			Pregnant		
Frequently Tired			Organ transplant			Nursing		
Thyroid Problem			Kidney Disease			Other		

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____ Date_____________________________
Signature of patient (or parent/guardian if minor