Established Patient- Dental/Medical History Update

Date: ______________________

Patient Name: ______________________ DOB: ______________________

CONTACT INFORMATION

Email: ______________________ Phone #: ______________________

Preferred method of contact: ○ Phone ○ Email

Any address change? ○ Yes ○ No

New address: ______________________

City: ______________________ Zip Code: ______________________

Any changes with dental insurance? ○ Yes ○ No

If yes: ______________________

PRIMARY CARE PHYSICIAN

Name: ______________________ Phone #: ______________________

DENTIST

Name: ______________________ Phone #: ______________________

Any change with your health since your last visit with us? ○ Yes ○ No

If yes: ______________________

Any surgeries or hospitalizations since your last visit with us? ○ Yes ○ No

If yes: ______________________

Date of surgery/hospitalization: ______________________

Any change in dental health since your last visit with us? ○ Yes ○ No

If yes: ______________________

Any new family history of cancer or other issues? ○ Yes ○ No

If yes: ______________________

Are you currently taking any medications or supplements (prescription and/or non-prescription) ? ○ Yes ○ No

If yes list medications: ______________________

Are you allergic to any medications, foods, or latex? ○ Yes ○ No

If yes: ______________________

Do you use any tobacco products? ○ Yes ○ No

If yes: ______________________

Females only: Are you pregnant? ○ Yes ○ No

Females only: Are you taking birth control? ○ Yes ○ No

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 his/her staff, responsible for any errors or omissions that I have made in my completion of this form.

Patient Signature **Date** ______________________

Submit