DENTAL MEDICAL AND HISTORY UPDATE

To ensure the highest quality of healthcare, we ask that you complete this patient update form.

Patient Name: _____ Date of Birth: _____

CONTACT INFORMATION

Phone Number (Home): _____ Cell: _____

Address: _____

PREFERED METHOD OF CONTACT (Select all that apply. Any changes to contact information, update below).

☐ Phone call ☐ Email ☐ Text message

Email address: _____

Any changes in insurance? YES ☐ NO ☐
EXPLAIN: _____

Any change in health since last dental visit? YES ☐ NO ☐
EXPLAIN: _____

Any surgeries or hospitalizations since last dental visit? YES ☐ NO ☐
EXPLAIN: _____

Are you being treated for any medical condition at present? YES ☐ NO ☐
EXPLAIN: _____

Any new family history of cancer or other serious health issues? YES ☐ NO ☐
EXPLAIN: _____

Are you taking blood thinners or diagnosed with a bleeding disorder? YES ☐ NO ☐
EXPLAIN: _____

Are you a diabetic? YES ☐ NO ☐
EXPLAIN: _____

Are you taking any medications or supplements (prescription and/or non-prescription)? YES ☐ NO ☐
EXPLAIN: _____

Have you discovered you are allergic to medications, foods, or latex? YES ☐ NO ☐
EXPLAIN: _____

Females only: Are you pregnant? 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, affiliated entities, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

_____ _____
Patient Signature Date

_____ _____
DDS/Hygiene Signature Date