



MEDICAL HISTORY UPDATE

Patient's Name: First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female

Patient's Address: \_\_\_\_\_

Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Physician: \_\_\_\_\_

Please indicate any changes to the patient's medical history: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please list any allergies: \_\_\_\_\_

\_\_\_\_\_

Please list any medications the patient is currently taking: \_\_\_\_\_

\_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

Is the patient having any discomfort at this time? \_\_\_\_\_

I hereby grant permission to the staff of this office for the administration of such anesthetics and the performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information as answered on this form is correct to the best of my knowledge.

I understand that I am financially responsible for the payment of any services rendered as well as broken appointment fees and all late payment service charges. Should I have dental insurance, I also understand that obtaining insurance coverage and benefit information as well as keeping up with the ever changing policies of my unique plan is my responsibility.

Patient name: \_\_\_\_\_ Date \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_