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**