DENTAL AND MEDICAL UPDATE

Please fill this form out completely so that we as a dental team can meet your dental needs using the most recent medical and dental information available.

Today's Date: ___________________

Home Phone #: ___________________ Work Phone #: ___________________ Cell Phone #: ______________________

To confirm appointments by email: ____Email Address

Name:____ Birth Date: ___/____/____ SS#_____________________________

Address:____

____
City State Zip code

Employed by:____ Occupation: _______________________________

Employer's Address: ____

Married _________ Single __________

DO YOU HAVE DENTAL INSURANCE? ________YES ________NO

Insured Name ____ Insured Date of Birth ______/_______/______

Insured Social Security #___________________________________ Insured Employer: ______________________________

Dental Insurance Co.: ______________________________________ Ins. Co. Phone #: _______________________________

Group # (plan, local, or policy #):_____________________________

ARE YOU COVERED BY A SECONDARY DENTAL INSURANCE PLAN? YES_____ NO_____

Insured Name ____ Insured Date of Birth ______/_______/______

Insured Social Security #___________________________________ Insured Employer: ______________________________

Dental Insurance Co.: ______________________________________ Ins. Co. Phone #: _______________________________

Group # (plan, local, or policy #):_____________________________

DO YOU HAVE:

Headaches frequently? __________ yes _________ times per week

Neck Pain frequently? __________ yes _________ times per week

Jaw Pain frequently? __________ yes _________ times per week

In case of an emergency, whom should we contact?:

Their name:___________________________ Phone #_____________________ Relationship to you____________________

(continued on back…)

MEDICAL HISTORY UPDATE

BP_____/____ Date______________

Are you currently under the care of a physician? Yes_____ No _____
Please explain:____
Physician's Name:______________________________Phone #_____________________________________
Your current physical health is : good_____ fair_____ poor_____
Please list any medications patient is currently taking and why patient is taking them :
____

Is patient allergic to any of the following? (Please check if yes)

Acrylic	_____	Sulfa	_____
Penicillin	_____	Aspirin	_____
Tetracycline	_____	Latex	_____
Erythromycin	_____	Metals	_____
Codeine	_____	Other	_____

Dental Anesthetics (Epinephrine, Novocain, etc.) _________________________

Has patient had any of the following diseases or medical problems? (Please check if yes)

Heart attack/stroke	_____	Radiation	_____
Heart murmur	_____	Cancer/Chemo	_____
Heart surgery	_____	Shingles	_____
Congenital heart def.	_____	Kidney disease	_____
Mitral Valve Prolapse	_____	Pacemaker	_____
		Artificial joints/bones	_____
Rheumatic fever	_____	Diabetes	_____
High blood pressure	_____	Hepatitis	_____
Low blood pressure	_____	Psychiatric care	_____
Artificial valves	_____	Epilepsy/seizures	_____
		Cold sores/herpes	_____
Hemophilia/blood dis.	_____	Drug/alcohol addict.	_____
Blood transfusions	_____	Venereal disease	_____
HIV+/AIDS	_____	Ulcers/colitis	_____
Anemia	_____	Arthritis	_____
		Frequent headaches	_____
Tuberculosis	_____	Sinus conditions	_____
Asthma	_____	Glaucoma	_____
Difficulty breathing	_____		
Emphysema	_____		

Have you been hospitalized recently? Yes_____ No _____ Reason: ___________________________

For Women:

Are you taking birth control pills? Yes ________ No ________
Are you pregnant? Yes ________ No ________
Are you nursing? Yes ________ No ________

For Men:

Do you take nitroglycerin? Yes ________ No ________
Are you taking Viagra? Yes ________ No ________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. **In the event that a health care worker comes in contact with my blood or other potentially infectious body fluids while treating me, I hereby consent to a hepatitis and HIV antibody test. These tests will be at no charge to me.**

X____ Date_____/_______/______
signature

Updated Health History (sign) _______________________________________ Date ___________
Updated Health History (sign) _______________________________________ Date ___________
Updated Health History (sign) _______________________________________ Date ___________
Updated Health History (sign) _______________________________________ Date ___________