Patient: ______________________________ Birthdate: __________ Date: __________

Address: ____

Phone: ____________________ E-Mail: ____________________________________

Dental Insurance: ____

MEDICAL HISTORY UPDATE:

Please Check "Yes" or "No" to indicate if you have any of the following:

Abnormal Bleeding………………...	□ Yes □ No	Hepatitis……………………….	□ Yes □ No
Artificial Bones/Joints/Valves……..	□ Yes □ No	High/Low Blood Pressure……	□ Yes □ No
Asthma……………………………...	□ Yes □ No	HIV+ or AIDS…………………	□ Yes □ No
Cancer/Chemotherapy…………….	□ Yes □ No	Recent Hospitalization………..	□ Yes □ No
Congenital Heart Defect…………..	□ Yes □ No	Liver Disease………………….	□ Yes □ No
Diabetes…………………………….	□ Yes □ No	Mitral Valve Prolapse………...	□ Yes □ No
Epilepsy……………………………..	□ Yes □ No	Pacemaker……………………	□ Yes □ No
Heart Attack………………………...	□ Yes □ No	Radiation Treatment…………	□ Yes □ No
Heart Murmur………………………	□ Yes □ No	Rheumatic/Scarlet Fever…….	□ Yes □ No
Heart Surgery………………………	□ Yes □ No	Seizures……………………….	□ Yes □ No
Hemophilia………………………….	□ Yes □ No	Sickle Cell Disease/Traits……	□ Yes □ No

FOR WOMEN ONLY:

Are you pregnant? □ Yes □ No Week # _________ Are you nursing? □ Yes □ No

ALLERGIES:

Please Check "Yes" or "No" to indicate if you are ALLERGIC to any of the following:

Aspirin……………………………….	□ Yes □ No	Latex……………………………	□ Yes □ No
Codeine …………………………….	□ Yes □ No	Metals…………………………..	□ Yes □ No
Dental Anesthetics……………….	□ Yes □ No	Penicillin………………………..	□ Yes □ No
Erythromycin……………………….	□ Yes □ No	Tetracycline……………………	□ Yes □ No
Jewelry……………………………...	□ Yes □ No	Sulfa Drugs……………………	□ Yes □ No

MEDICATIONS:

Please list all medications you take on a routine basis and what it's for:
If you carry a list, we will make a copy for you!

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

To the best of my knowledge all information above is complete and accurate. I understand that it is my responsibility to update the medical history for myself and my minor children.

____
Signature of Patient, Parent or Guardian

** For Office Use Only **

I have reviewed the previous information and updated it as necessary.

Updates: ____ Initial: ____ Date: _____

Updates: ____ Initial: ____ Date: _____