PATIENT UPDATE

Please help us keep our records current on our patients.

Patient's Name: _____ Date _____

Date of Last Examination _____

MEDICAL UPDATE

	Yes	No
1. Has there been any change in your health or medical history since the last visit?	❑	❑

Please explain: _____

_____

_____

2a. Have you had any history of or difficulty with any of the following? Please check Y or N

Y__ N__ A.I.D.S./H.I.V.	Y__ N__ Cerebral Palsy	Y__ N__ Hay Fever	Y__ N__ Mental Disability
Y__ N__ Anemia	Y__ N__ Cleft Lip/Palate	Y__ N__ Hearing Problems	Y__ N__ Rheumatic Fever
Y__ N__ Bladder Problems	Y__ N__ Convulsions	Y__ N__ Heart Problems	Y__ N__ Sinus Problems
Y__ N__ Blood Transfusion	Y__ N__ Developmental Disabillity	Y__ N__ Hepatitis	Y__ N__ Thyroid Disease
Y__ N__ Bruise Easily	Y__ N__ Diabetes	Y__ N__ Jaundice	Y__ N__ Tuberculosis
Y__ N__ Cancer	Y__ N__ Epilepsy	Y__ N__ Kidney Disease	Other_____
Y__ N__ Phen Phen	Y__ N__ Fainting	Y__ N__ Liver Disease	

Any medications taken? Yes____ No ____

Have you ever had any asthmatic attacks? If yes, Mild ____ Moderate ____ Severe ____ Frequency _____

2b. Are you allergic to, or ever had an adverse reaction to the following? If Yes, please circle

Aspirin	Barbiturates	Sedatives	Sulfa Drugs	Any others _____
Amoxicillin	Local Anesthetics	Sleeping Pills	Latex	

	Yes	No
3. Have you had any injuries to the teeth, head or neck since your last visit?	❑	❑

Please explain: _____

_____

_____

4. Is there any condition or problem you wish to bring to the Doctor's attention this visit?	❑	❑

Please explain: _____ Reviewed ❑

_____

_____

RECORD UPDATE

Address: _____ Phone: _____

E-mail: _____

	New	Used previously in this office	Any Changes
2. Do you have dental insurance covering this visit? Yes/No	❑	❑	❑

Authorization

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I also understand the use of anesthetic agents embodies a certain risk. I authorize the dental staff to perform the necessary dental services. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that responsibility for payment for dental services provided in this office are mine and are due and payable at the time services are rendered unless financial arrangements have been made IN ADVANCE. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I further understand that it is my responsibility to inform this office of any changes in my insurance coverage. I understand that credit bureau reports may also be obtained.

Patient Signature: _____ Date: _____