PATIENT INFORMATION UPDATE

(Please Print)

Date _____ Patient _____ Birthdate _____

Have there been changes in your address, telephone numbers, insurance or employment since your last visit? ☐ Yes ☐ No

Please specify _____

_____

Special concerns for today's visit _____

_____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Phone (_____) _____ Pharmacy _____ Phone (_____) _____

AIDS	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	**Have you ever had or been diagnosed with:**	
Chemotherapy	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No		
Circulatory Problems	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Artificial Heart Valves	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No	Artificial Joints, Screws, Pins, etc.	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No	Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	Blood Disease	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No	Congenital Heart Lesions	☐ Yes ☐ No
Fainting or dizziness	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Special Diet/Weight Loss	☐ Yes ☐ No	Hernia Repair	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Hepatitis Type _____	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Herpes	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No		

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please describe _____

_____

Have you ever been hospitalized or do you have any other health concerns? ☐ Yes ☐ No

If yes, please describe _____

_____

Women: Are you pregnant? ☐ Yes ☐ No

Due date _____

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Have you ever taken any of these medications?

Blood Thinners	☐ Yes ☐ No	Levoxyl	☐ Yes ☐ No
Coumadin	☐ Yes ☐ No	Synthroid	☐ Yes ☐ No
Warfarin	☐ Yes ☐ No		
Diet Medications	☐ Yes ☐ No		
Dexfenfluramine	☐ Yes ☐ No		
Fen-phen	☐ Yes ☐ No		
Pondimin	☐ Yes ☐ No		
Redux	☐ Yes ☐ No		

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.

☐ Yes ☐ No

Are you allergic to:

Aspirin	☐ Yes ☐ No	Latex	☐ Yes ☐ No
Barbiturates	☐ Yes ☐ No	Local Anesthesia	☐ Yes ☐ No
Codeine	☐ Yes ☐ No	Metals (i.e. gold)	☐ Yes ☐ No
Ibuprofen	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No

Other _____

Please PRINT all medications now taking: _____

_____

_____

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

DOCTOR'S COMMENTS & UPDATE

(to be completed by the dentist)

Medical Clearance Letter Sent to _____ Date _____

Results _____

Signature _____ Date _____