Health History Update

Today's Date ______________

Patient Name ______________________________ *Birth Date* ________________

Address ____

Phone (Home) ________________ (Work)____________________ (Cell) ________________

Email ______________________________ I would like my appointments reminders by? Text Phone Email

Primary Care Physician ____________________________ Phone ______________________________

Have you been admitted to the hospital or needed emergency care in the past two years? ________________

Please list all over the counter medications (including Vitamins) ______________________________________

Please list all prescription medications ____

Have you ever had any of the following? Please check all that apply:

- o AIDS/HIV Positive
- o Allergies
- o Anemia
- o Arthritis
- o Artificial Joints
- o Asthma
- o Blood Disease
- o Cancer
- o Codeine Allergy
- o Diabetes
- o Dizziness
- o Epilepsy
- o Excessive Bleeding
- o Fainting
- o Glaucoma
- o Growths
- o Hay Fever
- o Head injuries
- o Heart Disease
- o Heart Murmur
- o Hepatitis
- o High Blood Pressure
- o Jaundice
- o Kidney Disease
- o Liver Disease
- o Mental Disorders
- o Mitral Valve Prolapse
- o Nervous Disorders
- o Pacemaker
- o Penicillin Allergy
- o Radiation Treatment
- o Respiratory Problems
- o Rheumatic Fever
- o Rheumatism
- o Sensitive to Latex
- o Sinus Problems
- o Stomach Problems
- o Stroke
- o Tuberculosis
- o Tumors
- o Ulcers
- o Venereal Disease
- Other :____________

Women, are you Pregnant ? Yes No If Yes, Due Date ____________

Have you ever been asked to premedicate for a dental appointment? Yes No If Yes ________________

Are you sensitive to any metals, Jewelry? ________________________

Dental Insurance information:

I have Dental Insurance Yes No

My Dental Insurance information on file is correct ______________ (Please initial)

OR

Name of insured: ____________________________ DOB: ____________ Ins. ID #: ________________

Dental Plan Name and Address: ____

Dental Plan Phone Number ____

Consent for Service

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform your office at my next appointment with fail. As an established patient, I have been made aware of the Financial Policy, and I have been given a copy of the Notice of Privacy and understand my rights. I grant my permission to you to receive dental treatment.

Signature ____ Date __________________________________