

Medical Update

Patient Name: _____ **DOB:** _____

Emergency Contact: _____ **Emergency Contact Ph. #:** _____

Do you have or have you had any conditions listed below:

Heart Valve Replacement, Heart defects	YES	NO
Joint Replacement in the past two years	YES	NO
Diabetes	YES	NO
Hepatitis (any form)	YES	NO
HIV (Aids)	YES	NO

Other (Please explain): _____

Have you been treated with Bisphosphonate drugs (such as Fosamax, Boniva, Actonel, Aredia, Skelid and Didronel)? _____

Have you been to visit a physician since your last dental visit? YES NO

Please list the name and phone number of your physicians:

1. _____
2. _____
3. _____

Please list any medications, dosage & reason that you are taking:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Do you have any allergies or are you allergic to any medications? YES NO

If yes please list: _____

WOMEN: Are you pregnant? YES NO **Are you nursing?** YES NO

To the very best of my knowledge, the above information is true.

Patient Signature: _____ Date: _____

Staff Signature: _____ Dr. Initial: _____

Personal Information Update

Patient Name: _____ **DOB:** _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____ **Work:** _____

Email Address: _____

Spouse's Name: _____ **Spouse's Phone #:** _____

Emergency Contact (1): _____

Name

Phone #

Emergency Contact (2): _____

Name

Phone #

Dental Insurance Company ID/Group Number: _____

Dental Insurance Company Contact Number: _____

Patient Signature: _____ **Date:** _____