MEDICAL UPDATE FORM

TODAY'S DATE:

☐ Male ☐Female ☐Single ☐Married ☐Widowed ☐ Separated

Name: _____

Last **First** **MI** **Mr. Mrs. Ms. Dr.**

I preferred to be called: _____

DOB: / / **Age:** **S.S.#** _____

Address: _____

_____

Home#: _____ **Cell#:** _____

WK #: _____ **Email:** _____

Employer: _____

Employer Address: _____

_____

How long there? _____ **Occupation:** _____

Where and when is the best time to reach you? _____

Present Dentist: _____

Ph# _____ **How Long?** _____

Last visit date: _____

DENTAL INSURANCE

Insurance Name: _____

Insurance Co. Ph#: _____

Group #: _____ Policy# _____

Insured's Name: _____

Insured's SS#: _____

Insured's Birthday: _____

Insured's Employer: _____

Insured's Employer Number: _____

MEDICAL HISTORY

1. How would you describe your health?
☐ Excellent ☐Good ☐Fair ☐ Poor

2. Have you ever been hospitalized? Yes/No
If yes, what for? _____

3. Are you currently under the care of a Physician?
Yes/No If yes, please explain _____

_____

4. Physician's Name: _____
Physician Number: _____
Pharmacy #: _____

5. Do you need to Pre-Medicate prior to dental visits? Yes/No
If yes, what medications? _____

6. What Medications do you take? Including ASPIRIN & PLAVIX?

_____ _____

_____ _____

7. Are you taking birth control pills? Y/N Are you pregnant? Y/N

8. Are you Allergic to the following drugs?
☐Penicillin ☐ Codeine ☐Erythromycin ☐Tetracycline
☐Aspirin ☐Latex ☐Barbituates ☐Sleeping Pills
☐Dental Anesthetics ☐Sedatives ☐Other _____

Have you ever had the following? Please CHECK and Circle:

☐Kidney Problems	☐Venereal Disease
☐Psychiatric Problems	☐Sinus Problems ☐ Allergies
☐Heart Murmur	☐Hemophilia ☐ Abnormal Bleeding
☐Rheumatic Fever	☐High/ ☐ Low Blood Pressure
☐HIV ☐ AIDS	☐Osteoporosis/Meds for?
☐Heart Surgery/Pacemaker	☐Fever Blisters ☐ Shingles
☐Heart Attack ☐ Stroke	☐Ulcers ☐Colitis
☐Anemia ☐Radiation Treatment	☐Severe/Frequent Headaches
☐Drug/Alcohol Abuse	☐ Thyroid Problem
☐Cancer ☐Chemotherapy	☐Congenital Heart Defect
☐Asthma ☐ Arthritis	☐Blood Transfusion
☐Diabetes ☐Tuberculosis (TB)	☐Ephysema ☐Glaucoma
☐Epilepsy/Seizure/Fainting Spells	☐Difficulty Breathing
☐Artificial Bones/Joints	☐Artificial Valves/Stents
☐Mitral Valve Prolapse	☐Hepatitis ☐A ☐B ☐C ☐D ☐E

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. Furthermore, by signing below I am agreeing to the financial policy.

Signature: **Date:**