BENAGE
DENTAL CARE

PATIENT INFORMATION & HEALTH HISTORY UPDATE

Date: _____

Date of Birth: _____

Patient Name: _____

Address: _____

Cell Phone: _____

Have you had a change in your dental insurance? _____

Has there been any change in your health since we saw you last? _____

_____

Have you been hospitalized or had any surgeries since we saw you last? _____

_____

Are you taking any prescriptions or over-the-counter medications? _____

_____

_____

_____

_____

Are you required to take premedication prior to dental treatment? _____

Do you have allergies or adverse reactions to medications, jewelry, or metals of any kind? _____

_____

Do you have or have you had any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains
☐	☐	Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded
☐	☐	Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke
☐	☐	Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies
☐	☐	Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy
☐	☐	Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss
☐	☐	Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease
☐	☐	Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble
☐	☐	Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems
☐	☐	AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse
☐	☐	Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other

_____ _____

Signature of Patient Date

302 North Ridgeway Drive, Cleburne, TX 76033
Phone: (817) 641-6261 • Email: benagedentalcare@gmail.com • Web: benagedentalcare.com