PATIENT INFORMATION & HEALTH HISTORY UPDATE

Date: _____ Date of Birth: _____

Patient Name: _____

Address: _____

Cell Phone : _____ Home 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 pre- medication prior to dental treatment? _____

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

Signature: _____ Date:_____