PATIENT INFORMATION AND HEALTH HISTORY UPDATE FORM

Name_______________________________________Nickname_____________________Marital status: ______________

Address_______________________________________City_________________________________Zip_________________

Home phone ( )_________________Cell phone ( )__________________E-mail: ____________________________

Person to contact in case of Emergency_____________________________________( )__________________________

New Employer Name________________________________WORK NUMBER ( )_________________EXT______
New Employer Address___________________________________ City__________________________Zip_____________
Occupation____
If student, Name of School_____________________________________ Grade____ Year in College _________________

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New Dental Insurance____Ins phone( )___________________
Effective Date________________ *PLEASE GIVE INS. CARD & INFORMATION TO OUR RECEPTIONIST*
NOTES:

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MEDICAL HISTORY UPDATE: PLEASE ANSWER ALL QUESTIONS TRUTHFULLY . YOUR ANSWERS ARE CONFIDENTIAL, NECESSARY, AND IMPORTANT FOR YOUR DENTAL TREATMENT.

New Changes in Health____When diagnosed?________________

New Medications: ____[ ]See Attached list

New ALLERGIES to Medications or Foods____
New Physician Name and Phone Number____( ) _________________

Have you ever had or been exposed to the following?

LATEX ALLERGY? Yes / No Sensitivity to the powder in latex gloves? Yes / No Notes:____________________
BAD REACTION TO LOCAL ANESTHETICS? Yes / No Explain:____

Have you taken any diet pills containing "fen-phen", fenfluramine (Pondimin), dexfenfluramine (Redux)? Yes / No
If YES, you need to see your MD to examine your heart. You may need antibiotic Pre-med prior to dental treatment.

HIGH CHOLESTEROL? Yes / No DIABETES? Yes / No BACTERIAL ENDOCARDITIS? Yes / No

HEPATITIS A? Yes / No Vaccinated for Hepatitis A? Yes / No Notes:_____________________________
HEPATITIS B? Yes / No Vaccinated for Hepatitis B? Yes / No Notes:_____________________________
HEPATITIS C? Yes / No Notes: ____
HIV : tested positive? Yes / No Notes:____
CANCER? Yes / No Notes:____
TUBERCULOSIS? Yes / No ASTHMA? Yes / No SARS? Yes / No
Do you SMOKE? Yes / No Smoking increases risk for *cancer and periodontal disease.* Let us help you quit.
Do you SNORE? Yes / No Have you been diagnosed with SLEEP APNEA? Yes / No
Do you mouthbreathe? Yes / No Do you have chronic nasal congestion (stuffy nose)? Yes / No
Do you have sensitive teeth? Yes / No Do you have oral malodor (bad breath) ? Yes / No
Do you have any medical condition not listed? Yes / No Please Explain:_____________________________________

Patient or Legal Guardian Signature ____Date_____________________

Office use: Date entered in computer_________________Staff Initials_______________ Revised 9/30/2004