



PATIENT HISTORY UPDATE *(please print)*

If you need more space, please use the back of this page.

Filled out by (check one): Self ___ Mother ___ Father ___ Other: _____

1

Personal Information:

Name: _____ Title: _____ DOB: _____
 Home Address: _____
 Preferred Phone: _____ E-Mail Address: _____
 Home Phone: _____ Work Phone: _____ Cell: _____
Students: F/T ___ P/T ___ School _____
 Employer: _____
 Work Address: _____
 Marital Status: _____ Spouse's/Partner's Name: _____
 Spouse's Employer / Work Address: _____

For minors only: Parent(s) Name(s): _____
 Father's Work Phone / Address: _____
 Mother's Work Phone / Address: _____

Current Dental Insurance Information:

Company: _____ Policy#: _____ Group#: _____
 Employer's full name: _____
 Employee Name: _____ Employee Birth Date: _____
 Employee SS#: _____ Single/Family Coverage: _____

2

Medical History

Physician's Name: _____ Physician's Phone # _____

Physician's Address _____ Date Last Physical Exam: _____

Medications Currently Taking: _____

Please check if you have, or have ever had, any of the following conditions:

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Deafness | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Allergic to: |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis | Aspirin _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Hepatitis A / B / C | Penicillin _____ |
| <input type="checkbox"/> Artificial Joint / Rod / Pins | <input type="checkbox"/> Chemo / Radiation Therapy | Codeine _____ |
| <input type="checkbox"/> Herpes I or II | <input type="checkbox"/> Cancer / Malignancy / Tumor | Novocain _____ |
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Mentally Challenged / Autistic | Latex _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nervous / Psychiatric Problems | Other _____ |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Major Surgery _____ | Other conditions: |

3

Please sign and date, and bring your driver's license and insurance cards to the Front Desk.

Date: _____ **Signature:** _____

4

FOR LATER USE – If you need more space, please use the back of this page.

Date: _____	Changes: _____
Signature: _____	_____
Date: _____	Changes: _____
Signature: _____	_____