Patient Name: _____

MEDICAL HISTORY UPDATE

Insurance Coverage: N/A **[ ] Same [ ] Changed: _____**

1. Are you in good health? Yes No

2. Has there been any change in your health in the last 6 months? Yes No
   If yes, explain:

_____

3. Have you been hospitalized, had a major operation or serious illness in the past 6 months? Yes No
   If yes, explain:

_____

4. Date of your last visit to your medical doctor? _____ Reason for last visit:

_____

5. Are you currently receiving treatment or regular medical care by your doctor? Yes No
   If yes, for what condition(s)?

_____

6. Please list any current medications you are taking:

_____

7. Are you currently taking or have you taken Fosamax or any other meds related to osteoporosis? Yes No

8. Women Only: Are you pregnant or do you think you could be? Yes No

9. Please list any allergies you have:

_____

10. Are there any other problems that you know of? Yes No

If yes, please describe:_____

_____

11. **REMINDERS: Please indicate the form of reminder you would like 2 weeks prior to your appointment:**

- ☐ Email :_____
- ☐ Text message: _____
- ☐ Post card

Please indicate the form of reminder you would like 2 business days prior to your appointment:

- ☐ Email :_____
- ☐ Text message: _____
- ☐ Phone call: _____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give my permission to the dentist to obtain from my physician or dentist, any additional information regarding my medical history needed to provide me the best dental treatment possible.

PERSON COMPLETING FORM:

Signature:_____ Date:_____

If other than patient, indicate relationship: _____

SIGNATURE, ATTENDING DENTIST:_____ , DDS Date: _____