Patient Information Update Slip

Today's Date _____

Patient's Name _____

Mailing Address_____

City _____State_____Zip Code_____

E-mail Address_____

Telephone Number **Home#_____**

Work#_____

Cell#_____

Yes No

_____ _____ 1. Have there been any changes in your medical history since your last visit to this office? If yes, please describe _____

_____

_____ _____ 2. Have you been ill, hospitalized or any recent surgeries since your last visit to this office? If yes, please describe _____

_____

_____ _____ 3. Have you been under the care of a physician since your last visit to this office? If yes, please describe _____

_____

_____ _____ 4. List **ALL** current medications _____

_____

_____ _____ 5. Are you pregnant?

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Tetracyclin
Y	N	Codeine	Y	N	Latex	Y	N	Other
Y	N	Dental Anesthetics	Y	N	Penicillin			

Please list any other drugs/materials that you are allergic to: _____

_____

Name of Dental Insurance _____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical concerns.

_____

Signature

I have read my medical history dated _____ and confirmed that it states past and present medical concerns.

_____

Signature

I have read my medical history dated _____ and confirmed that it states past and present medical concerns.

_____

Signature

I have read my medical history dated _____ and confirmed that it states past and present medical concerns.

_____

Signature

I have read my medical history dated _____ and confirmed that it states past and present medical concerns.

_____

Signature

I have read my medical history dated _____ and confirmed that it states past and present medical concerns.

_____

Signature