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Medical Update

Please take a moment to update any changes to you personal information below.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

Primary Dental Insurance

Name of Insured: _____ (Last) _____ (First) ___ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Subscriber ID # _____

Group # _____

Secondary Dental Insurance

Name of Insured: _____ (Last) _____ (First) ___ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Subscriber ID# _____

Group # _____

Medical

Are you now under the care of a physician? * ◯ Yes ◯ No

If yes, please explain:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

Have you had any serious illnesses, or have been hospitalised in the last 5 years? If yes please explain

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *PreMed
- ☐ Allergy -Amoxicillin
- ☐ Allergy- Novocaine
- ☐ Allergy- Sulfa
- ☐ Alzheimer's Disease
- ☐ Artificial Joints
- ☐ Blood Clots/DVT
- ☐ Cold Sores-frequent
- ☐ Diabetes
- ☐ Fainting
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Parkinson's Disease
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Syncope
- ☐ Tourette Syndrome
- ☐ Vertigo
- ☐ ADHD
- ☐ Allergy Clindamycin
- ☐ Allergy- Other
- ☐ Allergy-Erythromycin
- ☐ Anemia
- ☐ Asperger Syndrome
- ☐ Blood Pressure- High
- ☐ Crohn's Disease
- ☐ Dizziness
- ☐ HIV / AIDS
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Past Pregnancy
- ☐ STD/HPV
- ☐ Sleep Apnea
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ xOther note below
- ☐ AFib
- ☐ Allergy- Codeine
- ☐ Allergy- Penicillin
- ☐ Allergy-Keflex
- ☐ Anxiety
- ☐ Asthma
- ☐ Blood Pressure- Low
- ☐ Dementia
- ☐ Emphysema
- ☐ Head Injuries
- ☐ Heart Surgery
- ☐ Jaundice
- ☐ Lymes Disease
- ☐ Nervous Disorders
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stomach Problems
- ☐ Tobacco Use
- ☐ Tumors
- ☐ Allergies-Food
- ☐ Allergy- Latex
- ☐ Allergy- Seasonal
- ☐ AllergyChlorhexidine
- ☐ Arthritis
- ☐ Auto immune disease
- ☐ Cancer
- ☐ Depression
- ☐ Epilepsy
- ☐ Heart Attacks
- ☐ Heart- Pacemaker
- ☐ Kidney Disease
- ☐ MRSA Infection
- ☐ Osteopenia
- ☐ Respiratory Problems
- ☐ Shingles
- ☐ Stroke
- ☐ Tonsil stones
- ☐ Ulcers

- ☐ Recent hospitalization (illness or injury)
- ☐ Tobacco Use- Smoke, Vape or Chew
- ☐ Chemical Dependency
- ☐ Cough that produces blood
- ☐ Presently being treated for any other illnesses/conditions
- ☐ Alcohol Dependancy
- ☐ Persistant cough greater then 3 weeks
- ☐ Been exposed to anyone with Tuberculosis

If any conditions or alerts selected above need further clarification, please describe below:

Women Only:

Please select all the apply:

- ☐ Currently Pregnant
- ☐ Currently Nursing
- ☐ Currently taking Birth Control
- ☐ Trying to get pregnant(Invitro)
- ☐ Hormone Replacement Therapy

Bone Density Treatment

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer? If yes treatment began

_____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax?) or risedronate (Actonel?) for osteoporosis or Paget's disease?

◯ Yes ◯ No

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? * ◯ Yes ◯ No

Do you take antibiotic premedication for your dental visits? * ◯ Yes ◯ No

Please explain your need to premedicate:

_____

_____

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you taking or have recently taken prescription or over the counter medication? ◯ Yes ◯ No

If so, it's important to include in the medications box below all vitamins, herbal, natural and or dietary supplements.

Please list any medications you are currently taking, one medication per line:

_____

_____

_____

_____

Physician Name and Phone Number:

_____

_____

Pharmacy Name and Phone Number

_____

_____

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Signature _____ **Date** _____

Response Date: _____