UPDATE

A-UPDATE - since your last visit:

1. Have you seen a medical doctor? Yes ☐ No ☐
2. Have you had a change in your medication? Yes ☐ No ☐
3. Have you had a change in your medical condition or had surgery? Yes ☐ No ☐
4. Have you had a change in home address or home and work phone numbers? Yes ☐ No ☐

Please note changes in health since last visit. If no changes, please write "none" _____

Signature _____ Date _____

B-UPDATE - since your last visit:

1. Have you seen a medical doctor? Yes ☐ No ☐
2. Have you had a change in your medication? Yes ☐ No ☐
3. Have you had a change in your medical condition or had surgery? Yes ☐ No ☐
4. Have you had a change in home address or home and work phone numbers? Yes ☐ No ☐

Please note changes in health since last visit. If no changes, please write "none" _____

Signature _____ Date _____

DO NOT WRITE IN THIS SPACE

INITIAL _____ FIRST VISIT: DATE _____

INITIAL _____ A-UPDATE: DATE _____

INITIAL _____ B-UPDATE: DATE _____

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WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental healthcare.

THE FOLLOWING CONFIDENTIAL INFORMATION IS FOR OUR RECORDS ONLY.

Patient: _____ Birth date: _____
(Dr., Mr., Mrs., Ms.) (First name) (Initial) (Last name)

Home address: _____ Phone: _____
(Street) (City) (ZIP)

Patient employed by: _____ How long? _____
(or parent if a minor)

Business address: _____ Phone: _____

Name of spouse: _____ Spouse employed by: _____

Spouse occupation: _____ Business phone: _____

If patient is a minor: _____
(give name of person legally responsible)

Do you have any dental insurance? _____ Name of insurance: _____

Name of referring dentist: _____ A patient how long? _____

Social Security Number: _____ (SS# is required for insurance and collection purposes. If no SS# given, payment in full will be required at a time of service)

Name and phone number of nearest friend or relative for emergency purposes: _____

HEALTH HISTORY

Please answer each question by checking the appropriate box Yes or No.

1. Are you in good health? Yes ☐ No ☐
2. Date of last physical examination? _____
3. Are you now under the care of a physician? Yes ☐ No ☐
   If yes, what is the condition being treated? _____
4. Have you ever had any serious illness, operation, or been hospitalized? Yes ☐ No ☐
5. Are you taking any medication? Yes ☐ No ☐
   If yes, what? _____
6. Are you taking any blood thinners? Yes ☐ No ☐
7. Are you using any recreational drugs (e.g., marijuana, cocaine) Yes ☐ No ☐
   If yes, what? _____
8. Have you ever been premedicated with antibiotics for your dental treatment? Yes ☐ No ☐

9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No-**Answer all conditions:**

Are you allergic to:

Y ☐ N ☐ ..... Aspirin?
Y ☐ N ☐ ..... Codeine?
Y ☐ N ☐ ..... Dental materials/metals?
Y ☐ N ☐ ..... Erythromycin?
Y ☐ N ☐ ..... Latex?
Y ☐ N ☐ ..... Penicillin?
Y ☐ N ☐ ..... Sulfa?
Y ☐ N ☐ ..... Other?_____

Cardiovascular:

Y ☐ N ☐ ..... Angina Pectoris
Y ☐ N ☐ ..... Congestive heart failure
Y ☐ N ☐ ..... Congenital heart lesions
Y ☐ N ☐ ..... Heart disease or attack
Y ☐ N ☐ ..... Heart murmur
Y ☐ N ☐ ..... High blood pressure
Y ☐ N ☐ ..... Low blood pressure
Y ☐ N ☐ ..... Mitral valve prolapse
Y ☐ N ☐ ..... Stroke

Hematology:

Y ☐ N ☐ ..... Anemia
Y ☐ N ☐ ..... Blood disorders
Y ☐ N ☐ ..... Blood transfusion
Y ☐ N ☐ ..... Bruise/swelling easily
Y ☐ N ☐ ..... Excessive bleeding
Y ☐ N ☐ ..... Hemophilia

Immuno/Neuro/Resp:

Y ☐ N ☐ ..... AIDS/HIV+
Y ☐ N ☐ ..... Cold sores
Y ☐ N ☐ ..... Herpes
Y ☐ N ☐ ..... Venereal disease
Y ☐ N ☐ ..... Artificial joint
Y ☐ N ☐ ..... Arthritis/rheumatism
Y ☐ N ☐ ..... Epilepsy/seizures
Y ☐ N ☐ ..... Fainting or dizzy spells
Y ☐ N ☐ ..... Glaucoma
Y ☐ N ☐ ..... Vertigo
Y ☐ N ☐ ..... Asthma/emphysema
Y ☐ N ☐ ..... Hay fever
Y ☐ N ☐ ..... Sinus condition
Y ☐ N ☐ ..... Tuberculosis

Other Health Conditions:

Y ☐ N ☐ ..... Allergies/hives
Y ☐ N ☐ ..... Alcoholism
Y ☐ N ☐ ..... Drug addiction
Y ☐ N ☐ ..... Diabetes
Y ☐ N ☐ ..... Nervous disorders
Y ☐ N ☐ ..... Cancer
Y ☐ N ☐ ..... Chemotherapy
Y ☐ N ☐ ..... Radiation therapy
Y ☐ N ☐ ..... Ulcers
Y ☐ N ☐ ..... Colitis
Y ☐ N ☐ ..... Hepatitis
Y ☐ N ☐ ..... Jaundice
Y ☐ N ☐ ..... Liver Disease
Y ☐ N ☐ ..... Rheumatic fever
Y ☐ N ☐ ..... Scarlet fever
Y ☐ N ☐ ..... Kidney disease
Y ☐ N ☐ ..... Thyroid/parathyroid disease

10. Do you use tobacco products? ☐ Cigarettes ☐ Cigars ☐ Chewing tobacco ☐ Snuff ☐ Other ..... Yes ☐ No ☐
    If yes, how much? _____
11. Have you ever taken the drug "fen-Phen" or "Redux"? ..... Yes ☐ No ☐
12. Is there anything we should know about your health that is not mentioned above? ..... Yes ☐ No ☐
    Please explain _____

Dental History

1. Have you ever had a local anesthetic (novocaine, etc.)? ..... Yes ☐ No ☐
2. Have you ever had any unfavorable reaction from local anesthetic? ..... Yes ☐ No ☐
3. Have you had any serious trouble associated with any previous dental treatment? ..... Yes ☐ No ☐
4. Does dental treatment make you nervous? ☐ Slightly ☐ Moderately ☐ Extremely ..... Yes ☐ No ☐

Women

1. Are you pregnant now? ..... Yes ☐ No ☐
2. Are you taking birth control pills? ..... Yes ☐ No ☐
3. Do you anticipate becoming pregnant? ..... Yes ☐ No ☐

Authorization

I, the undersigned, being the patient, parent, or guardian of the above minor patient, consent to the performing of whatever procedure may be decided upon to be necessary or advisable, in the opinion of the doctor and myself. I also have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I have also read and signed the attached Office Policy and Dental Materials Fact Sheet.

SIGNATURE _____ DATE _____

PAYMENT IS DUE IN FULL AT TIME OF SERVICE OR IF INSURANCE IS INVOLVED 20% DUE AT TIME OF SERVICE.