INFORMATION UPDATE

1. Name: _____ Date: _____

2. Since your last visit, have you had? (Please check yes or no)

a.) A name change? ..... □ Yes □ No If yes, Please update _____

b.) An address change? ..... □ Yes □ No If yes, Please update _____

c.) A dental insurance change? ..... □ Yes □ No If yes, Please update _____

d.) An employment change? ..... □ Yes □ No If yes, Please update _____

e.) A phone number change? ..... □ Yes □ No Home, work, cell? _____

3. Who is your physician?_____ Physician's Location: _____

4. Do you presently have any dental problems? If yes, what? _____ □ Yes □ No

5. Do you have to be pre-medicated for dental appointments? If yes, for what? _____

_____ □ Yes □ No

HEALTH HISTORY UPDATE

1. Are you allergic to any medications? If yes, Please list _____ □ Yes □ No

_____

Are you allergic to latex? ---------- □ Yes □ No

2. Are you under any medical treatment now? If yes, what for? _____ □ Yes □ No

3. Are you taking any medications at this time? If yes, please list all medications you are currently taking (prescription and over-the-counter, including Sinutab, Advil, etc.) _____ □ Yes □ No

_____

4. Are you taking any osteoporosis drugs? _____ □ Yes □ No

5. Do you use tobacco? If yes, what? _____ How Long? _____ □ Yes □ No

6. Do you use recreational drugs? ---------- □ Yes □ No

7. Do you have a joint prosthesis or replacement? If yes, what? _____ □ Yes □ No

Who is your orthopedist? _____

Where is he/she located? _____

8. Do you have any screws, plates or pins? ---------- □ Yes □ No

9. Females - Are you pregnant? ---------- □ Yes □ No

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

		When			When
1. High Blood Pressure	□ Yes □ No	_____	11. Hepatitis	□ Yes □ No	_____
2. Heart Attack	□ Yes □ No	_____	12. Cancer	□Yes □ No	_____
3. Mitral Valve	□ Yes □ No	_____	13. Aids/HIV	□ Yes □ No	_____
4. Angina	□ Yes □ No	_____	14. Diabetes	□ Yes □ No	_____
5. Heart Murmur	□ Yes □ No	_____	15. Tuberculosis	□ Yes □ No	_____
6. Pace Maker	□ Yes □ No	_____	16. Asthma	□ Yes □ No	_____
7. Other Heart Problems	□ Yes □ No	_____	17. Seizures	□ Yes □ No	_____
8. Rheumatic Fever	□ Yes □ No	_____	18. Joint Replacement	□ Yes □ No	_____
9. Respiratory Problems	□ Yes □ No	_____	19. Chemotherapy	□ Yes □ No	_____
10. Radiation Therapy	□ Yes □ No	_____	20. Glaucoma	□ Yes □ No	_____

AUTHORIZATION AND RELEASE: I certify that I have read and understand the above information and answered the questions accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period as such dental care was provided, to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly, to the dentist, benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependents.

Signature of patient (or parent, if minor): _____ **Date:** _____