Established Patient Dental/Medical Update

To insure the highest quality of healthcare, we ask that you complete this patient update!

Today's date _____ Patient name_____

Date of birth_____

Email address: _____ Phone number (H):_____

Phone number (C):_____

Address:_____

Preferred method of contact:_____

Person (s) to speak to regarding your care_____

Any changes to your insurance?_____

	NO	YES	If yes, explain
Any changes in your health since your last dental visit?			
Any surgeries or hospitalizations since last dental visit?			
Any changes in dental health since last dental visit?			
Any new family history of cancer or other health issues?			
Are you taking any medications or supplements?			
Are you allergic to any medications, foods, or latex?			
Do you use tobacco products?			
Females only: Are you pregnant?			
Females only : Are you taking birth control?			

I certify that I have read and understand the questions above. I have answered them correctly to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

X_____ **X_____**

Patient Signature or

Parent/Guardian Signature

Staff Signature