LIBERTY DENTAL ASSOCIATES

Glenn E. Casteel, D.M.D.
1251 Nilles Road Suite 13
Fairfield, Ohio 45014

CONFIDENTIAL HEALTH HISTORY UPDATE

ALL INFORMATION LISTED IS CONFIDENTIAL AND IS FOR MEDICAL PURPOSES ONLY

DATE: ___/___/_____ NAME:_____

MY E-MAIL ADDRESS: _____

PRE-MEDICATION REQUIRED? ☐YES ☐NO PER DR.

	CIRCLE	
1. Since your last dental appointment, have you been seen by a Medical Doctor? If yes, please list who, when, and for what: _____	YES	NO
2. Please list all medications (prescription or over-the-counter), drugs, or pills you are currently taking. If you have a list, please give this to the Office Coordinator so they can copy this. Include herbal medicines. _____ _____		
3. Please list any allergies (including medicines) you have: _____		
4. Are you having a dental problem today? If yes, please describe: _____ _____	YES	NO
5. Have you had any areas of soreness, discomfort, or pain in the mouth, or with your teeth? If yes, please describe: _____ _____	YES	NO
6. Do you have any type of heart stents, joint replacements, Mitral-valve Prolapse, or a condition which might require pre-operative antibiotics? If yes, please explain: _____	YES	NO
7. Do you have any other medical condition not listed? If yes, please list: _____	YES	NO
8. Do you like the way your teeth look and appear? If no, what would you change if you could: _____ _____	YES	NO

To the best of my knowledge, all of the preceding answers are true and correct.

_____
Signature of Patient, Parent, or Guardian

HU-1
REVISED 11-2009