BIRCHER
Family Dental Care

Established Patient – Dental Medical and History Update

To ensure the highest quality of healthcare, we ask that you complete this patient update form.

Today's Date: _____/_____/_____

Patient Name: _____   Date of Birth: _____

Reason for today's visit: _____

Contact information

    Email address: _____   Phone number: _____

    Address: _____

	NO	YES	IF YES, PLEASE EXPLAIN
Any changes in insurance?			
Any change in health since last dental visit?			
Any surgeries or hospitalizations since last dental visit?			
Any change in dental health since last dental visit?			
List any medical conditions you have			
Are you taking any medications or supplements (prescription and/or non-prescription)?			
Are you allergic to any medications, foods, or latex?			
Do you use any tobacco products?			
Females only: Are you pregnant?			
Females only: Are you taking birth control?			

I Certify *that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.*

X_____   X_____

       Patient Signature   Date