LARRY E. KREVITZ, DDS.

PATIENT UPDATE

Patient Name:_____ Age:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Home# _____ Cell#_____ Work#_____

Email address: _____

Dental Insurance:_____ ID# _____

Marital Status: Married_____Single_____ Partnered_____ Divorced_____Widowed_____

Are you happy with your smile? What would you change? _____

Emergency Contact: _____ Relation: _____ Phone# _____

MEDICAL HISTORY

Y__N__ Are you under medical treatment? For what? _____

Y__N__ Have you had any surgeries since your last visit? _____

Y__N__ Are you allergic to any medications? _____

Pharmacy name: _____ Phone# _____

HAVE YOU HAD ANY OF THE FOLLOWING?

Y__N__ heart attack-year _____ Y__N__ stroke-year_____

Y__N__ heart ailments _____ Y__N__ hip/knee replacement-year _____

Y__N__ hepatitis/type _____ Y__N__ weight loss surgery-year _____

Y__N__HIV/date of test _____ Y__N__ venereal disease/STD _____

Y__N__diabetes-insulin? _____ Y__N__ cancer/tumors-type _____

Y__N__ high blood pressure _____ Y__N__ pregnant/due date _____

Y__N__ birth control/type _____ Y__N__ natural supplements _____

Y__N__ blood thinners/aspirin therapy _____

Y__N__smoker? Cigarettes _____chewing tobacco _____ vape _____ other _____

CERTIFICATION: I CERTIFY THAT THE ANSWERS I HAVE GIVEN ARE CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____ **DATE** _____**STAFF INITIALS** _____