HEALTH HISTORY UPDATE

TODAY'S DATE:______/______/______

Name of Patient:____ Patient's DOB:___/___/______Age :_______
Patient Home Address:___________________________________ **City, State Zip:**____________________
Cell Phone:__________________________________ **Home Phone:**__________________________
Email:____
Emergency Phone Contact Name:___________________________**Phone #:**______________________________

Our appointment confirmation system requires an active cell phone number on file to confirm your dental appointments. You will receive a text message prior to your dental appointment and <u>it is necessary that you respond with only a letter C to this text message to ensure we can confirm your reserved appointment and avoid cancellation.</u>

Dental Insurance Carrier Name:________________________________**Insurance ID #:**________________________
Is this new insurance since your last visit? Y N ***If YES, please provide a copy of the insurance card.***

MEDICAL HEALTH HISTORY

❑ Y ❑ N **ARTIFICIAL JOINTS**
❑ **Knee** ❑ **Hip** ❑ **Heart Valve** ❑ **Other**________________
Date of replacement:___________________________
Surgeon:_____________________________________
Do you require Pre-Medication before Dental Visits? ❑Y ❑N

❑ Y ❑ N **Congenital Heart Lesions**
❑ Y ❑ N **Stroke** Date:_________________________
❑ Y ❑ N **Mitral Valve Prolapse**
❑ Y ❑ N **Heart Murmur**
❑ Y ❑ N **Scarlet Fever**
❑ Y ❑ N **Pacemaker**
❑ Y ❑ N **Heart Disease**

❑ Y ❑ N **Acid Reflux/GERD**
❑ Y ❑ N **Anemia**
❑ Y ❑ N **High Blood Pressure**
❑ Y ❑ N **Low Blood Pressure**
❑ Y ❑ N **Hepatitis Type:**__________________
❑ Y ❑ N **Diabetes Type:**__________________
❑ Y ❑ N **Kidney Disease**
❑ Y ❑ N **Liver Disease**
❑ Y ❑ N **AIDS or HIV**

❑ Y ❑ N **Cancer Type:**__________________
❑ Y ❑ N **Radiation/Chemotherapy Treatment**
❑ Y ❑ N **Thyroid Problems**
❑ Y ❑ N **Tuberculosis**
❑ Y ❑ N **Herpes/Cold Sores Frequency:**_____________
❑ Y ❑ N **Pregnant Due Date:**________________________
❑ Y ❑ N **Alcohol/Chemical Dependency**
❑ Y ❑ N **Abnormal bleeding after extractions or surgery?**
❑ Y ❑ N **Smoke or Tobacco Use?**
Amount per day?___________________________

Please note any condition, disease or medical problem not listed?

____
____

MEDICATIONS

Please ✔ *any medications you are currently taking*
Aspirin
Anticoagulants (blood thinners)
Antibiotics or sulfa drugs
High blood pressure medicine
Antidepressants or tranquilizers
Insulin, Orinase, or other diabetes drug
Nitroglycerin
Cortisone or other steroids
Osteoporosis (bone density) medicine
List All Medications <u>including</u> over the counter medicines, vitamins/supplements taken:

____
____
____
____

ALLERGIES

Please ✔ *or list any Allergies to material/medicines*
Penicillin or other Antibiotics **Latex**
Local anesthetics ("Novocain") **Sulfa**
Codeine or other narcotics **Aspirin**
Barbiturates (sleeping pills)_
Other Allergies: ____

Name of Physician:____
Physician Phone #:____

Preferred Pharmacy:____
Pharmacy Phone #:____

____
Printed Name of Person Completing form

____
Signature of Person Completing form

__________**Reviewing Dentist's Initials**