



Patient Name _____
(Please Print)

IF YOU HAVE HAD A CHANGE OF ADDRESS, PHONE #, OR EMPLOYER, PLEASE INDICATE ON THE APPROPRIATE LINE BELOW. IF THERE ARE NO CORRECTIONS, THEN GO TO QUESTION #1.

Address _____
Home Phone # _____ Cell # _____
Person responsible for payment of account:
Name _____
Address _____
Home Phone # _____ Cell # _____
Patient's (Parent's if minor) Employer _____
Work Phone # _____

To assist us in keeping your medical history up to date, please answer the following questions.

1. Have you seen your physician since your last visit? YES NO
If yes why? _____
2. Have you had surgery or been hospitalized since your last visit? YES NO
If yes, explain. _____
3. Are you taking any medication at the present time? YES NO
If yes, what and why? _____
4. Have you received any injections or blood transfusions within the last six months? YES NO
If yes, why? _____
5. Are you allergic to latex? YES NO
6. Women: Are you pregnant? YES NO
If so, what month? _____ Are you taking birth control pills? YES NO
7. Any injury to head or neck in the last six months? YES NO
If yes, what? _____
8. Any dental problems developed or developing that you are aware of? YES NO
9. Other dental or medical related concerns or problems?

Date _____ Signature _____