

## HEALTH HISTORY UPDATE

Patient Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Home Address: \_\_\_\_\_ Work # \_\_\_\_\_

1. Has your dental insurance coverage changed? \_\_\_\_\_ If yes, please give the name of the company: \_\_\_\_\_  
Group # \_\_\_\_\_ Policy # \_\_\_\_\_

*Please give card to receptionist so a copy of the card may be made for our records.*

2. Have there been any recent changes in your health?

\_\_\_\_\_  
\_\_\_\_\_

3. Have you recently required other medical services? \_\_\_\_\_  
If yes, nature of care: \_\_\_\_\_

4. Physician's name: \_\_\_\_\_

5. Have you been hospitalized recently? \_\_\_\_\_  
If yes, nature of the problem: \_\_\_\_\_

6. Any new illnesses? \_\_\_\_\_  
\_\_\_\_\_

7. Are you taking any medications(s) now? \_\_\_\_\_  
To treat: \_\_\_\_\_  
Medication and dosage: \_\_\_\_\_

8. Do you have any allergies or reactions to any drugs or medications? \_\_\_\_\_  
\_\_\_\_\_

9. Women: Are you pregnant? \_\_\_\_\_ Due date: \_\_\_\_\_

10. Any diseases, conditions or problems you think we should know about?

\_\_\_\_\_  
\_\_\_\_\_

11. Cell phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

12. How would you like us to confirm your appointments? (Please circle all that apply)

Home Phone

Cell Phone

E-Mail

Text Message

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_