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 # _______________________
Under whose name is it listed, if not your own_______________________
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 problem:____
____

6. Any new illnesses?____
____

7. Are you taking any medication(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?
____
____

Patient Signature:_____________________________________Date:_________