new dental images

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Medical History Update

Chart #. ____________
FOR OFFICE USE ONLY

Patient Name: ____________ ____________ ____ ____________
Last First MI Preferred Name

Title: ________ Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: ____________ SS #. ____________ Prev. Visit: ____________

Email Address: ____________ Best time to call: ____________

Phone: ____________ ____________ ____ ____________ ____________ ____________
Home Work Ext Mobile Fax Other

Address: ____________ ____________
____________ ____ ____________
City State Zip Code

Spouse's Name: ____

Address: ____

Phone #: ____

Email: ____

Emergency Contact Name: ____

Address: ____

Phone #: ____

Email: ____

Patient Name: ____ DOB: ______________________________

Financial Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: ____________ ____________ ____ ____________
Last First MI Preferred Name

Title: ________ Mr/Ms/Mrs/etc Gender: ○ Male ○ Female Family Status: ○ Married ○ Single ○ Child ○ Other

Birth Date: ____________ SS #. ____________ Driver's License #: ____________

Email Address: ____________ Best time to call: ____________

Phone: ____________ ____________ ____ ____________ ____________ ____________
Home Work Ext Mobile Fax Other

Address: ____________ ____________
____________ ____ ____________
City State Zip Code

Medical Conditions Updating

☐ ADD/ADDHD	☐ AIDS	☐ Allergies/Hives
☐ Anemia	☐ Anxiety	☐ Arthritis
☐ Aspirin Allergy	☐ Blood Trans	☐ Chest Pain
☐ Chronic Mastoid	☐ Chronic Sinus	☐ Codeine Allergy
☐ Cold Sores/Blisters	☐ Congenital Heart	☐ Coumadin
☐ Diabetes	☐ Down Syndrome	☐ Emphysema
☐ Epilepsy	☐ Fainting	☐ Fen-Phen
☐ Glaucoma	☐ HBP	☐ Heart Surgery
☐ Hemophilia	☐ Hepatitis	☐ Herpes
☐ HIV	☐ Jaundice	☐ Joint Replacement
☐ Kidney Problems	☐ Latex Allergy	☐ Liver Disease
☐ Mental Disorders	☐ MVP	☐ Other
☐ Pacemaker	☐ Penicillin Allergy	☐ Pondimen
☐ Pre-Med	☐ Prozac	☐ Psychiatric Treatmen
☐ Radiation Treatment	☐ Redux	☐ Rheumatic Fever
☐ Schizophrenia	☐ Seizures	☐ Stroke
☐ Sulfa Allergy	☐ Sulphur	☐ Thyroid
☐ Tuberculosis	☐ Tumors	☐ Venereal Disease

Patient Name: ____ DOB: ____________________________

Have you ever had to **Pre-Medicated** for any treatment? [ ] NO [ ] YES

If YES—Please List All Medications and Conditions: ___________________________________

____

Are there any surgeries or medical treatment including?

Currently: ____

Pending: ____

Past: ____

Are you **ALLERGIC** to any Medications? [ ] NO [ ] YES

If YES—Please List All Medications: ____

____

Please- List all the Current Medication that you are taking and Reasons:

Is there a possibility that you are or maybe PREGNANT (Female only)? [ ] NO [ ] YES

If Yes---How many weeks? _________________________________

Patient's Signature: ____ Date: _______________