



PATIENT HEALTH UPDATE

Date: _____
Name: _____ DOB _____ SS# _____
Spouse: _____ DOB _____ SS# _____
Address: _____ ZIP _____
Home #: _____ Cell #: _____
Employed By: _____ Business #: _____
E-Mail: _____
Spouse Employed By: _____

CURRENT DENTAL INSURANCE INFORMATION:

Dental Insurance Company: _____
Group #: _____ ID #: _____
Address: _____
Phone #: _____

Name of Physician: _____ Recent Surgery: _____ Date _____

Current Medications: _____

Do you currently have or have you previously had any of the following:

(Please Circle any that apply or let us know of any not listed)

Y N	AIDS/HIV +
Y N	Alzheimer's Disease
Y N	Anemia
Y N	Are you pregnant
Y N	Artificial Joints
Y N	Artificial Heart Valve
Y N	Asthma
Y N	Blood Disease
Y N	Blood Pressure
	High or Low
Y N	Blood Thinners
Y N	Blood Transfusion
Y N	Cancer
Y N	Chemotherapy
Y N	Diabetes
	Type: I or II
Y N	Drug Dependency

Y N	Epilepsy/Seizures
Y N	Prolonged Bleeding
Y N	Fainting
Y N	Heart Lesions or
	Valve Disorders
Y N	Hepatitis
	Type: A/B/C
Y N	Herpes
	Type: I or II
Y N	Jaundice
Y N	Kidney Disease
Y N	Liver Disease
Y N	Lung Disease
Y N	Pacemaker
Y N	Psychiatric Care
Y N	Radiation
Y N	Respiratory Problems

Y N	Rheumatic Fever
Y N	Sickle Cell Anemia
Y N	Stroke
Y N	Thyroid Disease
Y N	Tuberculosis
Y N	Ulcers
Y N	Venereal Disease
Y N	Allergy: Penicillin
Y N	Allergy: Latex
Y N	Allergy: Sulfa Drugs
Y N	Allergy: Ibuprofen
Y N	Allergy: Aspirin
Y N	Allergy: Codeine
Y N	Allergy: Epinephrine
Y N	Allergies: _____

Any others not listed: _____

How would you like to improve your smile? _____
