CONTACT AND MEDICAL INFORMATION UPDATE:

DENTAL HEALTH CENTERS

NAME_____ **EMAIL**_____

HOME PHONE _____ **WORK** _____ **CELL** _____

PREFERRED METHOD OF CONTACT: ☐ **HOME** ☐ **WORK** ☐ **CELL** ☐ **EMAIL**

(WOMEN ONLY) Are you taking birth control pills? Y N Are you pregnant? Y N Are you breastfeeding? Y N

Are you currently under the care of a physician? Y N If yes, for what reason? _____

Please list all allergies you have_____

Have you ever been advised to pre-medicate with antibiotics before having dental treatment? Yes No Reason_____

Please list all medications you are presently taking, including aspirin/baby aspirin and Cancer medications (Zometa/Aredia). Use additional page if needed_____

Ins. Name (If new or changed)_____

Employer (If new or changed)_____

DO YOU HAVE OR HAVE YOU EVER HAD:					
Arthritis	Yes	No	Circulatory problems	Yes	No
Asthma or hay fever	Yes	No	Heart Murmur	Yes	No
Congenital heart defects	Yes	No	Rheumatic fever	Yes	No
Abnormal blood pressure	Yes	No	Chemical dependency	Yes	No
Diabetes	Yes	No	Fainting spells	Yes	No
Epilepsy	Yes	No	Excessive urination/thirst	Yes	No
Cancer	Yes	No	Malignant Hypothermia	Yes	No
Psychiatric care	Yes	No	HIV Positive	Yes	No
Radiation therapy	Yes	No	Excessive or prolonged bleeding	Yes	No
Stroke	Yes	No	Taking blood thinner medication	Yes	No
Prosthetic implant	Yes	No	Sinus trouble	Yes	No
Tuberculosis or lung disease	Yes	No	Thyroid problem	Yes	No
Hepatitis	Yes	No	Pace Maker	Yes	No
Herpes simplex (cold sores)	Yes	No	Tumors	Yes	No
Latex Allergy	Yes	No	Kidney disorders	Yes	No
			Heart disease	Yes	No

Primary Care Physician and Clinic _____

I certify that I have read and understand the above information to the best of my knowledge. I authorize my insurance company to pay directly The Dental Health Center any insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependents, regardless of insurance coverage.

Patient Signature_____ Date_____

Parent or Guardian, if minor

FOR OFFICE USE ONLY Verbal updates:

Patient Initials _____ Date_____ Name of new med_____

Patient Initials _____ Date_____ _Name of new med_____