

## PATIENT INFORMATION UPDATE

Name \_\_\_\_\_ Date \_\_\_\_\_

Home Address \_\_\_\_\_  
Street or Box No. City State Zip

Home Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Father's Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Mother's Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Subscriber \_\_\_\_\_ Policy# \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone \_\_\_\_\_

### Medical/Dental History:

- |   |   |   |
|---|---|---|
| 1. Are you under medical treatment now?                         | Y | N |
| 2. Have you ever been hospitalized (surgery or illness)?        | Y | N |
| 3. Are you taking any medications (including non-prescription)? | Y | N |
| 4. Do you use tobacco?  | Y | N |
| 5. Do you use alcohol, cocaine, or other drugs?                 | Y | N |
| 6. Do you have or have you had any of the following?            |   |   |

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting/Seizures
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Hay Fever/Allergies	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Hepatitis/Jaundice
<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Stomach Troubles/Ulcers
<input type="checkbox"/> Implant	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Stroke	<input type="checkbox"/> Other _____	

7. Are you allergic to or have you had any reaction to the following?

<input type="checkbox"/> Penicillin or other antibiotics	<input type="checkbox"/> Sulfa Drugs
<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Sedatives	<input type="checkbox"/> Pain Medications
<input type="checkbox"/> Local anesthetic (e.g. Novocaine)	<input type="checkbox"/> Other _____

- |  |   |   |
|--|---|---|
| 8. Do you feel pain in any of your teeth?                                | Y | N |
| 9. Have you had any head, neck, jaw, or mouth injuries?                  | Y | N |
| 10. Do you clench or grind your teeth?                                   | Y | N |
| 11. Do you bite your lips or cheeks frequently?                          | Y | N |
| 12. Do you have frequent headaches?                                      | Y | N |
| 13. Do your gums bleed while brushing or flossing?                       | Y | N |
| 14. Are your teeth sensitive to hot, cold, sweet, or sour liquids/foods? | Y | N |
| 15. WOMEN ONLY:  |   |   |
| Are you pregnant or think you may be pregnant?                           | Y | N |
| Are you nursing?   | Y | N |
| Are you taking birth control pills?                                      | Y | N |