Medical History Update

Patient's Name _____ Date _____

Home _____ Work / Cell _____

Email _____

Has there been any change in the patient's health since last dental appointment? ☐ Yes ☐ No

If so, what? _____

Is the patient taking any kind of medication at this time? ☐ Yes ☐ No

If so, what? _____

Does the patient have an allergy (or adverse reaction) to any medication? ☐ Yes ☐ No

If so, what? _____

Does the patient have any current or past heart problems? ☐ Yes ☐ No

If so, what? _____

Has the patient had any surgeries or anesthesia since last visit? ☐ Yes ☐ No

If so, what? _____

Does the patient have a latex allergy? ☐ Yes ☐ No

Do you have a specific concern regarding your child's visit today?

_____

Is your child under the care of an orthodontist? _____ Whom? _____

Last Visit: _____ Next Visit: _____

If there have been any changes in address and insurance since patients last visit with us please update below:

Home Address _____

City _____ State _____ Zip _____

Phone(s) _____

Insurance Information:

Insurance Name _____

Employer _____

Insured's Name _____

Subscriber ID # _____ Date of Birth _____/_____/_____

Group Number _____ Phone Number _____

I give permission to complete the recommended treatment. I understand that I am responsible for any charges incurred for today's visit and any balance owed after the insurance has considered plan limitations, co-insurance, and deductibles.

Print Name _____ Relationship to Patient _____

Signature _____ Date _____

Office Use Only: Age _____ B/P _____//_____ Photo ☐ Y ☐ N

Height _____ Weight _____ kg NPO: _____ Pulse_____ Resp Rate_____