Existing Patient Update

This is a patient update. We require one to be filled out each year. Also, if your dental insurance changes, it is your responsibility to inform our front office. Thank you.

Patient Name:_____Today's Date: _____
Date of Birth:_____Home Phone:_____Work Phone:_____
Cell Phone:_____Mailing Address:_____
Emergency Contact and Phone #:_____
Pharmacy:_____E-Mail Address:_____

Allergies: (Please Circle) Penicillin Codeine Latex
Aspirin Local Anesthetic Erythromycin

List any others: _____

Do you have doctor's orders to **PRE-MEDICATE BEFORE DENTAL TREATMENT**?_____

CIRCLE ANY OF THE FOLLOWING YOU HAVE HAD OR CURRENTLY HAVE:

Heart Attack	AIDS/HIV	Bruise Easily	Heart Disease	Hepatitis A
Hepatitis B	Emphysema	Asthma	Angina Pectoris	High Blood Pressure
Heart Murmur	Rheumatic Fever	Congenital Heart	Lesion	Mitral Valve Prolapse
Artificial Joints	Anemia Stroke	Kidney Trouble	Ulcers	Liver Disease
Blood Transfusion	Drug Addiction	Hemophilia	Fever Blister	Epilepsy
Seizures	Nervousness	Psychiatric Treatment	Glaucoma	Chemotherapy
Venereal Disease	Tuberculosis	Hay Fever	Sinus Trouble	Allergies
Hives	Diabetes	Thyroid Disease	Radiation	Arthritis
Cortisone Medicine	Pain in Jaw Joints	Alcoholism	Cosmetic Surgery	H1N1 Virus

List All Medications: _____

_____

_____

Medical History: _____

_____

_____

General Medical Physician:_____

Patient Signature:_____