PATIENT'S INFORMATION **Please Print Clearly!**

(First) __________________________ (MI) ______ (Last) _____________________(DOB)_____________

Address: ____________________________________ City/St: __________________Zip: ______________

Land Line Phone: ___________________________ Work Phone: _________________EXT: ____________

Cell Phone: ____

Employer: _________________________________ Email: _______________________________________

EMERGENCY CONTACT:

Name: ____ **Phone**: ________________________________

Relationship: __________________________________

MEDICAL UPDATE

To keep our medical records current, please answer the following questions to the best of your knowledge.

1. Are you seeing a physician or been hospitalized since your last visit YES/NO

   If yes, please explain: ____
2. Are you taking any medications? YES/NO

   List medications &reason for taking: ____
3. Do you have any heart problems, had heart surgery or have an artificial heart valve? YES/NO

   Explain: ____
4. Do you have any medical problems? YES/NO

   Explain: ____
5. Are there any drug allergies? YES/NO

   Explain: ____
6. Do you have any joint implants? YES/NO

   Explain: ____
7. Are you on chemotherapy or radiation treatment? YES/NO
8. Do you smoke or use tobacco? YES/NO
9. Do you take any anticoagulants or blood thinners? YES/NO
10. Do you take any medications for osteoporosis or low bone density? YES/NO

Date: _________________ ____

Patient/ Parent/ Guardian's Signature

Person responsible for account: ____

Dental Insurance (Please supply us with an insurance card): _____________________________________