



Welcome Update

Established Patient- Dental, Medical, and History Update

To ensure the highest quality of healthcare, we ask that you complete this patient update form. **Note: If you have not been seen in our office for over a year, a new complete medical history is required.**

TODAY'S DATE: ____/____/____

Patient Name:	Date of Birth:
Preferred Method of Contact:	
<input type="checkbox"/> Email Address #: _____	<input type="checkbox"/> Home #: _____
<input type="checkbox"/> Cell #: _____	
Home Address:	Zip Code:

	NO	YES	IF YES, PLEASE EXPLAIN:
Any changes in Dental Insurance?	<input type="checkbox"/>	<input type="checkbox"/>	
Has there been any change in your health since your last appointment?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any Major Health Issues, Surgeries, or Hospitalizations since your last visit?	<input type="checkbox"/>	<input type="checkbox"/>	
Has there been any change in your dental health since your last appointment?	<input type="checkbox"/>	<input type="checkbox"/>	
NEW family history of cancer or other health issues since your last visit?	<input type="checkbox"/>	<input type="checkbox"/>	
Please list all medications &/or supplements - prescription & /or non-prescription.	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever taken bisphosphonates, antiresorptive, or antiangiogenic drugs (medicine that effects bone growth or metabolism)?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you Allergic to any medications, foods, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use any tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>	

FEMALE ONLY

Are You Pregnant:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are You Taking Birth Control	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I Certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

X	X	X	X
Signature of Patient (Parent or Guardian if Minor)	Date	Reviewed By Staff (Signature)	Date