MEDICAL HISTORY UPDATE

UPON CHECK IN PLEASE MAKE THE NECESSARY CHANGES TO YOUR INSURANCE, ADDRESS AND CONTACT INFORMATION

PATIENT'S NAME: ____ DOB: ________________________

ADDRESS CHANGES? ____

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EMERGENCY CONTACT NAME & PHONE #: ____

PREFERRED APPOINTMENT REMINDER CONTACT:

EMAIL ____________________________ HOME ____________________ CELL/TEXT ________________________

PLEASE UPDATE INSURANCE INFORMATION 24 HOURS BEFORE YOUR APPOINTMENT DATE

DO YOU REQUIRE PREMED FOR PREVIOUS SURGERY? YES / NO **DID YOU TAKE IT TODAY? YES / NO**

CURRENT MEDICAL PHYSICIAN'S NAME & PHONE #: ____

HEALTH CHANGES OR CONCERNS SINCE LAST VISIT?

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____

PROVIDE ALL CURRENT MEDICATIONS

____

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PROVIDE ALL ALLERGIES

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PATIENT/GUARDIAN'S SIGNATURE: _______________________________________ DATE_____________________

DENTIST'S SIGNATURE: ____ DATE_____________________

TO AVOID POSSIBLE OFFICE FEES 48 HOUR'S NOTICE IS REQUIRED DURING BUSINESS DAYS FOR CONFIRMATIONS AND/OR APPOINTMENT CHANGES