Please answer the following to enable us to update your dental records.
the Information Is, of course, confidential.

Patient's Name (first) _____ (middle) _____ (last) _____ Today's Date _____

Home Address _____ Apt# _____ Home phone _____

City _____ State _____ Zip _____ Business phone _____

E-mail address _____ Birth Date _____

Social Security Number _____ Cell _____

Name of Person responsible for services rendered:

_____ Relationship _____

All fees for professional services are due and payable at the time treatment is rendered. We accept Visa, Mastercard and Personal Checks.

Signature _____

MEDICAL UPDATE

Insurance Carrier Name _____ Group# _____

Please check if you have any of the following:

_____ ANEMIA
_____ ABNORMAL BLEEDING
_____ HIGH BLOOD PRESSURE
_____ CONGENITAL HEART LESIONS
_____ RHEUMATIC FEVER
_____ MITRAL-VALVE PROLAPSE
_____ KIDNEY OR LIVER TROUBLE
_____ ASTHMA
_____ SINUS TROUBLE
_____ HEPATITIS
_____ TUBERCULOSIS
_____ HIV POSITIVE
_____ FOSAMAX AND/OR BONIVA BOTH FOR OSTEOPOROSIS
_____ AIDS
_____ CARCINOMA (CANCER)
_____ ULCERS
_____ DIABETES
_____ DRUG ALLERGIES
_____ HEART MURMUR

Are you presently taking any medication? _____ If yes, please advise us. _____

Females only: could you now be pregnant? _____ YES _____ NO

Have you been advised by your physician to be on the Prophylactic Antibiotic before each dental appointment? _____

_____ I have reviewed the above medical list and there are no further changes.

Signature _____ Date _____