MEDICAL RECORD UPDATE

NAME: _____ DATE: _____

EMAIL: _____ CELL PHONE: _____

ADDRESS CHANGE? _____

Do you have any current health problems? YES ☐ NO ☐

If so, please explain:

Are you under a physician's care now? YES ☐ NO ☐

If so, please explain:

What medications are you currently taking and for what condition?

_____

_____

Are you allergic or have you reacted adversely to any medications, food, latex, local anesthesia or nitrous oxide? If yes, please explain:

_____

Is there anything you wish to discuss with the dentist today? YES ☐ No ☐

ARE YOU HAPPY WITH YOUR SMILE? YES ☐ NO ☐

DO YOU WISH YOUR TEETH WERE WHITER? YES ☐ NO ☐

HAS THERE BEEN ANY CHANGE TO YOUR DENTAL INSURANCE? YES ☐ NO ☐

New carrier: _____ Group Number: _____

Employer: _____ Subscriber Name and ID: _____

HOW DO YOU PREFER TO BE CONTACTED?

CELL PHONE: _____ TEXT: _____ EMAIL: _____ HOME PHONE: _____ WORK PHONE: _____