MEDICAL HISTORY UPDATE

PLEASE PRINT

Date _____

Patient's Name _____ Nickname _____

Home Address _____ Home Phone _____

City _____ State _____ Zip _____

Age _____ Birth date _____ Female/Male _____

MEDICAL HISTORY

YES	NO		YES	NO	
☐	☐	Heart Murmur	☐	☐	Hepatitis/Liver Disease
☐	☐	Rheumatic Fever	☐	☐	Kidney Disease
☐	☐	Asthma	☐	☐	Diabetes
☐	☐	Heart Disease	☐	☐	Epilepsy
☐	☐	Thyroid Disease	☐	☐	Nervous Disorder
☐	☐	High Blood Pressure	☐	☐	Tumor, Cancer
☐	☐	Lung Disease	☐	☐	Cardiac Pacemaker
☐	☐	Metallic Implant, Shunts, Pins or Rods	☐	☐	Measles
☐	☐	Sore Throats	☐	☐	Tonsillitis
☐	☐	Tuberculosis	☐	☐	Ear aches
☐	☐	Chicken Pox	☐	☐	Glaucoma
☐	☐	Prolonged Bleeding When Cut	☐	☐	Mumps
☐	☐	Blood Transfusion	☐	☐	Bad Breath
☐	☐	Injury to Front Teeth	☐	☐	Stained Teeth
☐	☐	Bleeding Gums	☐	☐	Cold Sore, Fever Blister
☐	☐	**DRUG/FOOD ALLERGY** If yes, to what medications/foods? _____	☐	☐	Women: Are you Pregnant Now?
			☐	☐	AIDS
			☐	☐	Chemical Dependency
☐	☐	ADD /ADHD Attention Deficit Disorder/ Attention Deficit Hyperactivity Disorder	☐	☐	Developmentally Delayed Age level patient is at _____

COMMENTS
(for Office Use Only)

Is the patient taking any medications? **Yes** ❑ **No** ❑

If so, please list the medications: _____

Has the patient recently been under the care of a physician? **Y** ❑ **N** ❑ Reason: _____

Name of Medical Doctor for above reason: _____

RESPONSIBLE PARTY INFORMATION

Resident Parent _____
Last First Middle Initial Marital Status

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address: _____

Previous Address(if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birth date _____ Relationship to patient _____

Employer _____ Occupation _____ Yrs. Employed _____

Other Parent _____
Last First Middle Initial

Address (if not the same) _____
Street City State Zip

Social Security # _____ Birth date _____ Relationship to patient _____

Home Phone _____ Work Phone _____

Employer _____ Occupation _____ Yrs. Employed _____

DENTAL INSURANCE INFORMATION

Primary Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Insurance Phone # _____

Do You have dual coverage? ☐ Yes ☐ No

Secondary Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Insurance Phone # _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____ Phone _____

_____
Signed (Parent or Guardian)