



FAMILY DENTISTRY AND ORTHODONTICS

PATIENT INFORMATION UPDATE

Patient Name: Last First MI Preferred

Address: Street City Zip Code

Circle appropriate: Minor Single Married Divorced Email address:

SS#: Birth Date: Gender: Male/Female

Phone: Home Work Ext. Cell

Employer: If student, name of school

If Minor, Parent or Guardian Name:

Parent or Guardian Employer:

Person to contact in case of an emergency: Phone Number

PATIENT MEDICAL HISTORY

Physician: Phone: Date of last exam:

Do you have, or have you ever had any of the following?

Table with 4 columns of medical conditions and symptoms, each with a checkbox. Includes categories like Allergies, Blood Disease, High Blood Pressure, and Women Only.

- Have you been admitted to a hospital or undergone surgery during the past two years? Yes No
• Are you under the care of a physician? Yes No Have you taken steroids in the last 2 years? Yes No
• Are you currently taking any medications? If yes, please list:
• Do you have any health problems that need further clarification? Yes No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X Signature of patient (or Parent/Guardian if minor)

Date