Medical History Update Sheet

Patient Name:	Phone: InsuranceCarrier:	
Email Address:		
1. Have you had any changes in your medical history since your last visit?	Yes	No
2. Are you currently taking any medications?	Yes	No
If you answered "Yes" please list medications below:		
 3. Do you have any food or latex allergies? 4. Have you been hospitalized since the last time you were here? 	Yes Yes	No No
I have reviewed my MEDICAL HISTORY datedand confirm present conditions.	n that it adequa	itely states past and
Patient/Guardian Signature:	Date:	
Dental Provider Signature:	D	ate:



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ent Name:Pho		none:	
Email Address:	Insurance	InsuranceCarrier:	
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