Medical History Update Sheet

Patient Name:_____ Phone: _____

Email Address: _____ InsuranceCarrier: _____

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? Yes No
4. Have you been hospitalized since the last time you were here? Yes No

I have reviewed my MEDICAL HISTORY dated _____and confirm that it adequately states past and present conditions.

Patient/Guardian Signature:_____ Date:_____

Dental Provider Signature:_____ Date:_____

The DENTAL COLLECTIVE

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The DENTAL COLLECTIVE