MEDICAL HISTORY UPDATE

PATIENT NAME	TELEPHONE

MEDICAL HISTORY UPDATE **DATE**______________

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what condition? ____

Are you taking any medication or herbal supplements at this time? ☐ Yes ☐ No

If so, what ____

Do you have any allergies or adverse reactions to any medication? ☐ Yes ☐ No

If so, what ____

Has there been any change to your dental insurance since your last dental appointment? ☐ Yes ☐ No

If so, what ____

______________________________ Patient Signature ______________________________ Doctor Signature

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