

**MEDICAL UPDATE**  
**(TO BE COMPLETED YEARLY)**

Patient Name: \_\_\_\_\_ Home phone \_\_\_\_\_

E-mail address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home address \_\_\_\_\_ Work Phone: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ zip-code \_\_\_\_\_

Marital Status: Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widow(er) \_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**MAY WE CALL YOU AT WORK REGARDING APPOINTMENTS?** ..... **YES** \_\_\_ **NO** \_\_\_

**HAS YOUR DENTAL INSURANCE CARRIER CHANGED...? YES** \_\_\_ **NO** \_\_\_

**IF SO, WHAT IS THE NAME OF YOUR NEW CARRIER** \_\_\_\_\_ **ADDRESS** \_\_\_\_\_

**POLICY NUMBER** \_\_\_\_\_ **TEL #** \_\_\_\_\_

**ARE YOU A FULL TIME STUDENT? Y** \_\_\_ **N** \_\_\_ **NAME AND ADDRESS OF COLLEGE** \_\_\_\_\_

HAS YOUR MEDICAL HISTORY CHANGED SINCE YOUR LAST VISIT? **YES** \_\_\_ **NO** \_\_\_

IF YES, IN WHAT WAY? \_\_\_\_\_

HAVE YOU SEEN A PHYSICIAN SINCE YOU LAST VISIT? **YES** \_\_\_ **NO** \_\_\_

IF YES, WHY? \_\_\_\_\_ **PHYSICIAN'S NAME & PHONE** \_\_\_\_\_

**Women only:**

Are you Pregnant or think you may be pregnant? Y \_\_\_ N \_\_\_ if yes, when are you do? \_\_\_\_\_

Are you nursing? Y \_\_\_ N \_\_\_

Are you taking birth control pills? Y \_\_\_ N \_\_\_

HAVE YOU HAD HEART VALVE AND OR PROSTHETIC REPLACEMENT SURGERY? **YES** \_\_\_ **NO** \_\_\_

IF YES, WHAT? \_\_\_\_\_ WHEN? \_\_\_\_\_

ARE YOU TAKING ANY PRESCRIPTION OR NON-PRESCRIPTION MEDICATION? **YES** \_\_\_ **NO** \_\_\_

IF YES, WHAT ARE YOU TAKING \_\_\_\_\_ FOR WHAT? \_\_\_\_\_

HAVE YOU RECEIVED ANY INJECTIONS OR BLOOD TRANSFUSIONS IN THE PAST 6 MONTHS **YES** \_\_\_ **NO** \_\_\_

HAVE YOU BEEN TESTED FOR AIDS, MONONUCLEOSIS, OR HEPATITIS? **YES** \_\_\_ **NO** \_\_\_ IF YES, WHICH \_\_\_\_\_

AND DID YOU TEST **NEGATIVE** \_\_\_ OR **POSITIVE** \_\_\_

DURING THE PAST 6 MONTHS, HAVE YOU HAD: PNEUMONIA, PERSISTENT COUGH, FATIGUE, EPISODES OF DIARRHEA,

OR BURNING MOUTH? **YES** \_\_\_ **NO** \_\_\_ IF YES, WHICH? \_\_\_\_\_

ARE YOU BEING TREATED FOR HEART PROBLEMS OR HIGH / LOW BLOOD PRESSURE? **YES** \_\_\_ **NO** \_\_\_

IF YES, WHICH? \_\_\_\_\_

HAVE YOU RECEIVED RADIATION THERAPY OR CHEMOTHERAPY IN THE PAST 6 MONTHS? **YES** \_\_\_ **NO** \_\_\_

IF YES, WHICH? \_\_\_\_\_ FOR WHAT? \_\_\_\_\_

HAVE YOU HAD ANY ADVERSE REACTIONS OR ALLERGIES TO ANY MEDICATIONS? **YES** \_\_\_ **NO** \_\_\_

IF YES, WHICH MEDICATIONS? \_\_\_\_\_

DO YOU PLAY ANY SPORTS, IF SO, WOULD YOU BE INTERESTED IN A CUSTOM FIT SPORTS GUARD? **YES** \_\_\_ **NO** \_\_\_

ARE YOU HAPPY WITH YOUR SMILE? **YES** \_\_\_ **NO** \_\_\_ DO YOU FEEL YOUR TEETH COULD BE STRAIGHTER? **YES** \_\_\_ **NO** \_\_\_ IF YES,

WOULD YOU BE INTERESTED IN INVISALIGN? **YES** \_\_\_ **NO** \_\_\_

WOULD YOU BE INTERESTED IN WHITENING YOUR TEETH? **YES** \_\_\_ **NO** \_\_\_

DO YOU SMOKE CIGARETTES OR USE TOBACCO PRODUCTS SUCH AS CHEW? **YES** \_\_\_ **NO** \_\_\_ IF YES, WHICH \_\_\_\_\_

IN ADDITION TO PERFORMING A ROUTINE ORAL CANCER EVALUATION, WE NOW RECOMMEND VIZILITE WHICH IS AN ADVANCED ORAL CANCER SCREENING. WOULD YOU LIKE TO HEAR MORE INFORMATION ABOUT THIS PROCEDURE? **YES** \_\_\_ **NO** \_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**(Please review and sign privacy notice on back of this form)**