# PATIENT INFORMATION UPDATE

Name ______________________________________ Date of Birth__________________ Date___________________

Address_______________________________________________________________________________________________

______________________________________________ E-mail _________________________________

Home phone _______________________ Cell _______________________ Work __________________________

***Please indicate best contact number with an asterisk***

Emergency Contact ______________________________________________ Phone ______________________

Dental Insurance Co. ________________________________________ ID # _______________________________

Address ___________________________________________ Phone # ____________________________

## HEALTH HISTORY

General Health (please check) Excellent ___ Good ___ Fair ___ Poor ___

Have you ever had a serious head or neck injury? ___________________________________________________

Have you been under the care of a physician in the past two years? _____ For_ _____________________________

Are you allergic to: (*Circle Please*) Penicillin Sulfa Other antibiotics Aspirin Codeine Local anesthetics

Latex Rubber Acrylic Any Metals Other (please list) _____________________

Please ***check yes or no*** if you have had or have at present any of the following:

| Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|
| Abnormal blood pressure | Yes □ | No □ | Fainting | Yes □ | No □ |
| Allergies - seasonal | Yes □ | No □ | Glaucoma | Yes □ | No □ |
| Alzheimer’s diagnosis | Yes □ | No □ | Heart Attack – when_______ | Yes □ | No □ |
| Anaphylaxis | Yes □ | No □ | Heart Disease | Yes □ | No □ |
| Anemia | Yes □ | No □ | Hepatitis – type ______ | Yes □ | No □ |
| Angina | Yes □ | No □ | Herpes | Yes □ | No □ |
| Arthritis | Yes □ | No □ | HIV positive/ AIDS | Yes □ | No □ |
| Artificial Heart Valve | Yes □ | No □ | Jaundice | Yes □ | No □ |
| When ________ | | | Kidney Disease | Yes □ | No □ |
| Artificial Joints | Yes □ | No □ | Liver Disease | Yes □ | No □ |
| What/When_________________________ | | | Lung Disease | Yes □ | No □ |
| Asthma | Yes □ | No □ | Mental Disorders | Yes □ | No □ |
| Autoimmune Disease | Yes □ | No □ | Organ Transplant: | Yes □ | No □ |
| Blood Disorders | Yes □ | No □ | What/When________________________ | | |
| Cancer: (currently: Y N ) | Yes □ | No □ | Osteoporosis | Yes □ | No □ |
| Canker Sores/Cold Sores | Yes □ | No □ | Prolonged cough | Yes □ | No □ |
| Cardiac Pacemaker | Yes □ | No □ | Radiation therapy | Yes □ | No □ |
| Celiac Disease | Yes □ | No □ | Respiratory problems | Yes □ | No □ |
| Chemotherapy | Yes □ | No □ | Rheumatic Fever | Yes □ | No □ |
| Colitis | Yes □ | No □ | Sinus Problems | Yes □ | No □ |
| Congenital Heart Lesions | Yes □ | No □ | Stroke – when _______ | Yes □ | No □ |
| Depression/Anxiety | Yes □ | No □ | Swollen ankles | Yes □ | No □ |
| Diabetes | Yes □ | No □ | Thyroid disease | Yes □ | No □ |
| Drug /Alcohol Dep.Treatment | Yes □ | No □ | Tuberculosis | Yes □ | No □ |
| Eating Disorder | Yes □ | No □ | Ulcers/Gastric reflux | Yes □ | No □ |
| Emphysema | Yes □ | No □ | Venereal disease | Yes □ | No □ |
| Epilepsy | Yes □ | No □ | Vertigo | Yes □ | No □ |
| Excessive Bleeding | Yes □ | No □ | Other ______________________________ | | |

*WOMEN*: Are you pregnant or nursing? ____________ Taking Birth Control or hormones? _____________

*MEN*: Are you taking Viagra? ___________

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing Bisphosphonates? ________

Please list all medications you are currently taking, including OTC and Naturopathic:

| Condition | Medication | Dosage |
| --- | --- | --- |
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*To the best of my knowledge, all of the information on this form is true and correct. If there is any change in my health, or my medications, I will inform the doctor prior to any treatment.*

**Signature** _______________________________ **Date** ______________________