Elegant Dentistry

MEDICAL HISTORY UPDATE

Name: _____ DOB: _____/_____/_____ Sex: F M

Address: _____

City: _____ State: _____ Zip: _____ Phone: _(_____) _____-_____

Email: _____

Emergency Contact: _____ Phone: _(_____) _____-_____

Have you had any recent serious illnesses or operations? YES NO If YES please describe: _____

_____

Are you currently under a physicians care? YES NO If YES, please describe: _____

_____

PLEASE CIRCLE IF YOU CURRENTLY HAVE ANY OF THE FOLLOWING:

Artificial Heart Valves	AIDS/HIV Positive	Psychiatric Care	Dental Phobic
Aspirin _____mg	Hepatitis: A B C	Thyroid Disease	Hemophilia
Diabetes: Type 1 Type 2	High Blood Pressure	Hard of Hearing	Dementia
Mitral Valve Prolapse w/Regurgitation	Seizures or Fainting	Kidney Disease	Pregnant
Previous Infectious Endocarditis	Cardiac Transplant	Blood Thinners	Asthma
Congenital Heart Disease	High Cholesterol	Tobacco Habit	MRSA
Other: _____	Liver Disease	Pace Maker	Stroke

Artificial Joints: _____ Date: _____ Bone Replacement Meds Date: _____

Have your ever had an adverse reaction to a medical or dental procedure? NO YES

If yes, please explain: _____

Is the patient currently taking any medications (INCLUDING OVER THE COUNTER & HEALTH FOOD SUPPLEMENTS?) Please list: _____

_____

Does the patient have any drug allergies? YES NO If YES, please describe: _____

_____

I have reviewed the information on this medical update and it is accurate to the best of my knowledge. I have read and understand the notice of practices. **I understand that I am financially responsible for all charges whether paid or not by insurance. All patients are required to take full mouth series x-rays or FMX, every 3 to 5 years; depending their oral and medical health. Bitewing x-rays are required minimum once a year.**

Signature: _____ Date: _____/_____/_____

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