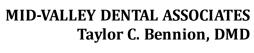
MEDICAL HISTORY UPDATE





Name:			The state of the s
Physicians Name:		_ Date of last physical:	
Have you had any serious illness	or operations? yes no	If yes, describe:	
For female patients only: Are you pregnant? yes no _	Nursing? yes no	Taking birth control pills?	? yes no
Do you require antibiotics prior t	o dental treatment? yes n	0	
Please check if you have or hav	e had any of the following:		
☐ AIDS ☐ Alzheimers, Dementia, memory loss ☐ Anemia ☐ Artificial joints ☐ Artificial heart valve ☐ Asthma ☐ Back problems ☐ Blood disease ☐ Cancer ☐ Chemical dependency ☐ Chemotherapy ☐ Other (describe): MEDICATIONS:			Psychiatric care Respiratory disease Radiation treatment Rheumatic fever Shortness or breath Skin rash Stroke Thyroid problems Tobacco habit Tonsillitis Ulcers Venereal disease
Are there any changes to your	contact or insurance informa	ntion? yes no <i>If yes, p</i>	olease fill out the sections be
CONTACT INFORMATION:			
Address:		City:	State: Zip:
Home phone:	Mobile:	Wor	k:
Email:		·	
INSURANCE INFORMATION:			
Primary insurance carrier:	Subsc	riber ID No:	Group No:
•	Subscriber ID No:		-
•			
EMERGENCY CONTACT			
Name:	Relationship to patient:		Phone:
——————————————————————————————————————	ave read and answered the abo	ve questions to the best of my k	nowledge.
Signature of patient (or of parent o	or guardian if natient is a mino	 r)	