

MEDICAL HISTORY UPDATE

PLEASE PRINT

Date _____
Patient's Name _____ Nickname _____
Home Address _____ Home Phone _____
City _____ State _____ Zip _____
Age _____ Birth date _____ Female/Male _____

MEDICAL HISTORY

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorder
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Metallic Implant, Shunts, Pins or Rods	<input type="checkbox"/>	<input type="checkbox"/>	Measles
<input type="checkbox"/>	<input type="checkbox"/>	Sore Throats	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Ear aches
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding When Cut	<input type="checkbox"/>	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Bad Breath
<input type="checkbox"/>	<input type="checkbox"/>	Injury to Front Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Stained Teeth
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sore, Fever Blister
<input type="checkbox"/>	<input type="checkbox"/>	DRUG/FOOD ALLERGY	<input type="checkbox"/>	<input type="checkbox"/>	Women: Are you Pregnant Now?
		If yes, to what medications/foods?	<input type="checkbox"/>	<input type="checkbox"/>	AIDS
<input type="checkbox"/>	<input type="checkbox"/>	ADD /ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency
		Attention Deficit Disorder/	<input type="checkbox"/>	<input type="checkbox"/>	Developmentally Delayed
		Attention Deficit Hyperactivity Disorder			Age level patient is at _____

COMMENTS
(for Office Use Only)

Is the patient taking any medications? **Yes** **No**

If so, please list the medications: _____

Has the patient recently been under the care of a physician? **Y** **N** Reason: _____

Name of Medical Doctor for above reason: _____

RESPONSIBLE PARTY INFORMATION

Resident Parent _____
Last First Middle Initial Marital Status
Address _____
Street City State Zip
Home Phone _____ Work Phone _____ Cell Phone _____
E-mail Address: _____
Previous Address(if less than 3 yrs.) _____
Street City State Zip
Social Security # _____ Birth date _____ Relationship to patient _____
Employer _____ Occupation _____ Yrs. Employed _____
Other Parent _____
Last First Middle Initial
Address (if not the same) _____
Street City State Zip
Social Security # _____ Birth date _____ Relationship to patient _____
Home Phone _____ Work Phone _____
Employer _____ Occupation _____ Yrs. Employed _____

DENTAL INSURANCE INFORMATION

Primary Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____ Insurance Phone # _____
Do You have dual coverage? Yes No
Secondary Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____ Insurance Phone # _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____ Phone _____

Signed (Parent or Guardian)