Annual Medical Update

Name_____ Date of Birth_____

Have you had any of the following changes?

Address_____

Phone (HM)_____ (WK)_____ (Cell)_____ ok to text Y/N

Email_____

Insurance company_____ Employer_____
ID#_____ Group #_____ Insurance Phone# _____

Health problems you have, or medications you may be taking could have an important interrelationship with the dentistry you receive. Please answer the following:

What medications are you currently taking? _____
Are you currently taking a blood thinner? Y/N _____
Are you taking Fosomax, Boniva, Actonel or any other medications containing bisphosphonates?
Y/N_____

Have you been hospitalized in the last year? Y/N if yes, please explain_____

Have you had any serious illness in the last year? Y/N if yes, please explain_____

Do you have any new allergies? Y/N, if yes, please explain_____

Do you have any new dental concerns? Y/N, if yes please explain_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature_____ Date_____