Annual Update Form for Current Patients

Email: **Cell #:** **Date**

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable lows. Please note that you will be asked about responses to this questionnaire and there may be additional questions concerning your health. This information is vital and to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Home Phone: ( ) Work Phone: ( )

Address: City: State: Zip:

Mailing address

Did your Dental insurance change?_____

DENTAL INFORMATION

Has your dental health changed since your last visit?_____

_____

Are you here for routine care?_____

Did you want to address a specific dental need today with your dentist?_____

_____

MEDICAL INFORMATION

ALLERGIES: **Please check "yes" or "no" to any allergies you have.** To all **yes** responses please specify what you are allergic to type and severity of reaction. (Use the back of this form for additional space.)

Yes	No		Yes	No		Yes	No		Yes	No	
❒	❒	Local Anesthetics	❒	❒	Sulfa Drugs	❒	❒	Aspirin	❒	❒	Codeine or other narcotics
❒	❒	Antibiotics	❒	❒	Metal	❒	❒	Iodine	❒	❒	Barbiturates
❒	❒	Hay fever/Seasonal	❒	❒	Animals	❒	❒	Food	❒	❒	Sedatives or sleeping pills
❒	❒	Latex (rubber)	❒	❒	Other						

Do you or have you had Multiple myeloma or metastatic cancer?
Date Treatment began:_____

Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
Date:_____ If yes, have you had any complications?_____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Bonivia, Reclast, Prolia) for osteoporosis or Paget's disease? _____

Since 2001, were you treated or are you presently scheduled to begin taking an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease?_____

Has a physician or previous dentists recommended that you take antibiotics prior to your dental treatment?
Name of physician or dentist making recommendation_____
Phone number: ( )_____

Do you have any disease, condition, or problem not listed above that you think I should know about?
Please explain:_____

WOMEN ONLY: Are you pregnant?_____ Are you nursing? _____ Are you using birth control pills or hormone replacement therapy?_____

MEDICAL INFORMATION **Please check yes or no.**

Do you wear contact lenses?_____

Do you use controlled substances (drugs)?_____

Do you use tobacco (smoking, snuff, Chew, Bidis)? _____

If so, how interested are you in stopping? *Circle one*: Very / Somewhat / Not interested

Do you drink alcoholic beverages?_____

If yes, how much did you drink in the last 24 hours?_____

If yes, how much do you typically drink in a week?_____

Are you now under the care of a physician?_____Physician Name_____

Has there been any change in your health within the past year?_____

If yes, please explain._____

Have you had a serious illness, operation or been hospitalized in that past 2 years?_____

If yes, please explain?_____

Are you taking or have you recently taken any prescription or over the counter medicine?_____

If yes, please list all, including vitamins, natural or herbal preparation on/or dietary supplements:

_____

_____

Please check "yes" or "no" to indicate whether you have had or have any of the following conditions or diseases. If necessary explain yes answers below.

Yes	No		Yes	No		Yes	No		Yes	No	
❒	❒	Artificial Heart Valve	❒	❒	Angina	❒	❒	Arteriosclerosis	❒	❒	Congestive Heart Failure
❒	❒	Congenital heart defect	❒	❒	Damaged heart valve	❒	❒	Heart attack	❒	❒	Heart disease
❒	❒	Heart murmur/MPV	❒	❒	Heart surgery	❒	❒	Low blood pressure	❒	❒	High blood pressure
❒	❒	High cholesterol	❒	❒	**Pacemaker**	❒	❒	Endocarditis	❒	❒	Rheumatic fever
❒	❒	Abnormal bleeding	❒	❒	Anemia/Hemophilia	❒	❒	AIDS/HIV	❒	❒	Arthritis/Rheumatoid Arthritis
❒	❒	Autoimmune disease	❒	❒	Lupus/Erythematous	❒	❒	Asthma/Bronchitis	❒	❒	Emphysema
❒	❒	Tuberculosis	❒	❒	Cancer/Chemotherapy	❒	❒	Radiation	❒	❒	Excessive urination
❒	❒	Glaucoma	❒	❒	Eating disorder	❒	❒	Ulcer	❒	❒	Gastrointestinal issues
❒	❒	Stomach Problems	❒	❒	Hepatitis/Liver Disease	❒	❒	Kidney problems	❒	❒	Thyroid Problem
❒	❒	Stroke	❒	❒	Seizure	❒	❒	Epilepsy	❒	❒	Osteoporosis
❒	❒	Sleep disorder	❒	❒	Snoring/Sleep apnea	❒	❒	Swollen neck glands	❒	❒	Headaches/Migraines
❒	❒	Recurrent infections	❒	❒	Neurological Disorder	❒	❒	Mental disorder	❒	❒	Night sweats
❒	❒	Weight loss/gain	❒	❒	Diabetes						

_____

_____

Do you have any disease, condition, or problem not listed above that you think I should know about?

Please explain:_____

Reviewed by doctor:_____

Note: Both doctor and patient(s) are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient/Legal Guardian **Print Name** **Date**