UPDATED MEDICAL & BILLING INFORMATION	YOU MUST FILL OUT THIS FORM ENTIRELY

PATIENT NAME:_____

Have you seen your physician since your last visit with us? If so, why?	Y N
Have you EVER had surgery? If so, what kind and when?	Y N
List any medications to which you are allergic	
Are you latex allergic?	Y N
Do you need to take antibiotic premedication? If yes, did you take it, what antibiotic, and how much?	Y N
Have you EVER had a diagnosis of tuberculosis, a persistent cough of over 3 weeks, or a cough that produces blood?	Y N
Do you use tobacco?	Y N
Are you a full-time student? If so, what school do you attend?	Y N

Check if Yes	Medical Condition	MEDICATION	Check if Yes	Medical Condition	MEDICATION
	Pregnancy (currently)			Fainting	
	High Blood Pressure			Seizures	
	Heart Problems			Osteoporosis	
	Cardiac Pacemaker			Arthritis	
	Heart Valve Replace.			Joint Replace./Implant	
	History Endocarditis			Stomach Issues/Ulcer	
	Stroke			Thyroid Problem	
	Swollen Ankles			Cancer (currently?)	
	Asthma / Allergies			Radiation / Chemo.	
	Respiratory Problems			AIDS or HIV Infection	
	Diabetes			Orally Transmit. Dis.	
	High Cholesterol			Glaucoma	
	Liver Disease			Recent Weight Loss	
	Hepatitis (which one?)			Depression	
	Kidney Disease			Other Prescriptions	

NON-PRESCRIPTION MEDICATIONS	YOUR PHARMACY
1. 2. 3. 4.	**1. Name:** **2. Location:** **3. Phone #:**

Tell a front desk staff member if your address or phone numbers have changed

Dental Insurance:_____
Company Name Subscriber Name

_____
Employer Subscriber ID # Group #

Patient Signature:_____ Date:_____

Doctor Signature:_____ Date:_____