Patient Update

First Name______________________________________ **Email**____

Last Name______________________________________ **Cell**____________________ **DOB**___________________

Has your address changed?

Yes __________________________

No

Has your insurance changed?

Yes (please provide front desk)

No

Are you having COVID symptoms?

Yes

No

Are you awaiting COVID results?

Yes

No

Surgeries In The Last Year?

Yes (explain)______________________

No

Pre-Med required?

Yes

No

Had joint replacement?

Yes

No

Artificial Heart Valve?

Yes

No

Heart Problems?

Yes (explain)____________________

No

Circle what applies to you

Pregnant

Osteoporosis

Heart Disease

Autoimmune Disease

Prolonged Bleeding

High/Low Blood Pressure

Lung Disease/Asthma/TB

Emphysema

Hepatitis

Diabetes

Hypoglycemia

Aids/HIV

Allergies (other than meds)

Neurological

Kidney Disorder

Glaucoma

Stomach Problems

Irregular heartbeat/Atrial fibrillation

Had Local Anesthesia

Sensitive Teeth

Pain/Popping in Jaw

Regular Headache

Bleeding Gums

Epilepsy/Seizures

Mental Disorder

Wear Denture/Partial

Anxiety/Depression

Pain Med addiction

Autism/Aspergers

Medications you are TAKING (if none put N/A)

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Medications you are ALLERGIC to (if none put N/A)

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*The above information is correct to the best of my knowledge.

Patient Signature _____________________________________ Date ______________________________

Parent/Guardian Signature (if under 18) ____