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# Medical Health History - Update

Patient s Name: _____ Birth Date:_____ Today's Date: _____
Address: _____ City: _____ State ____ Zip _____
Marital Status: _____ Home Phone: _____
Place of Employment: _____ Business Phone: _____
Email: _____ Cell Phone: _____
Physician s Name: _____ Referred To Us By: _____
Dental Insurance Co. Name: _____
Most Convenient Day & Time For Your Dental Appointments: _____
Purpose of This First Dental Visit: _____
_____

*Person Financially Responsible For This Account:* _____
*Address:* _____ *Home Phone:* _____
*Employment Name & Address:* _____ *Social Security No.:* _____
*Emergency Contact* _____ *Phone* _____
*Is it okay to contact your Emergency Contact with your present medical condition?* ____ *Yes* ____ *No*

**Please check the best answer, and complete the blank lines where appropriate:**

- Has there been any change in your health in the last few years: . . . . . ____ Yes ____ No
  If YES, what:_____
- Have you undergone medical treatment for anything in the last year? . . . . . ____ Yes ____ No
- Are you on any medications now (including birth control pills)? . . . . . ____ Yes ____ No
  List: _____
- Do you have any allergies? . . . . . ____ Yes ____ No
- Do you use dental floss daily? . . . . . ____ Yes ____ No
- Have you neglected replacing missing teeth? . . . . . ____ Yes ____ No
- Check if you have ever had: ☐ rheumatic fever or rheumatic heart disease; ☐ recent by-pass surgery: ☐ prosthetic valve replacements; ☐ mitral valve prolapse; ☐ pacemaker; ☐ pros-thetic joint replacements; ☐ rheumatoid arthritis; ☐ lupus erythematosus; ☐ chemotherapy; ☐ high or low blood pressure; ☐ nervous disorders; ☐ hepatitis; ☐ venereal disease; ☐ ulcers; ☐ epilepsy; ☐ sinusitis; ☐ cancer; ☐ anemia; ☐ bleeding disorders; ☐ thyroid or kidney disease; ☐ tuberculosis; ☐ immune system diseases, Other communicable diseases . . . . . ____ Yes ____ No
  If YES, Please list these or others: _____
  _____

- Is there any reason to believe that you are in a high risk group for AIDS or other immune system illness: . . . . . ____ Yes ____ No
  If YES, Please explain: _____

Do you still have your tonsils?. . . . . ____ Yes ____ No
Do you wake up often when you are sleeping?. . . . . ____ Yes ____ No
Do you wake up from a night's sleep feeling refreshed or do you feel tired and groggy?. . . . . ____ Yes ____ No
Are you interested in dental implants(tooth replacement) or other treatments to replace missing teeth?. . . . . ____ Yes ____ No

Have you had a joint replacement - _____ knee _____ hip _____ shoulder and/or _____ toe? ____ Yes ____ No

Please list your major dental concerns at this time: _____

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**Click SUBMIT button to send your completed form to our office. This button only works in Acrobat.**
**If you are having trouble, you can send the form in an email to: info@chemungfamilydental.com**

SUBMIT