Chemung
FAMILY DENTAL

RICHARD B. DUNN, DDS
DIPLOMATE OF ABDSM
1007 BROADWAY
ELMIRA, NY 14904
(607)734-2045
WWW.CHEMUNGFAMILYDENTAL.COM

MEDICAL HEALTH HISTORY UPDATE

Patient's name: _____ Birth Date:_____ Today's Date: ____

Address:_____ City:_____ State:____Zip:_____

Marital Status: _____ Cell Phone:_____

Email:_____ Home/Business Phone:_____

Place of Employment:_____

Dental Insurance Co.:_____

Best Time/Day For Your Appointments:_____

Person Financially Responsible For This Account:_____

Address:_____ Phone:_____

Employment Name & Address:_____ Social Security No.:_____

Emergency Contact:_____ Phone:_____

May we contact your Emergency Contact in regard to your present condition? Yes No

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

*Has there been a change in your health in the past few years? Yes No
If YES,please explain:

*Have you undergone any medical treatments recently: Yes No
If YES, please explain:

*Are you on any medications (include birth control): Yes No
Please list:

*Do you have any allergies? Yes No

*Do you floss daily? Yes No

*Do you have missing teeth you would like to replace? Yes No

*Please check if you have had:

rheumatic fever/heart disease; recent bypass surgery; prosthetic valve replacement; mitral valve prolapse; pacemaker; prosthetic joint replacements; rheumatoid arthritis; lupus; chemotherapy; high/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? Please list:_____

*Do you still have your tonsils? Yes No

*Do you have any sleep issues you would like addressed? Yes No

THE HIGHEST COMPLIMENT OUR PATIENTS CAN GIVE, IS THE REFERRAL OF THEIR FAMILY AND FRIENDS.
THANK YOU FOR YOUR CONFIDENCE
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