To ensure the highest quality of healthcare, we ask that you complete this patient update form.

Today's Date: ____/____/_____

Patient Name: _____

Contact Information

Email Address: _____ Phone Number: _____

Address: _____

Preferred Method of Contact: _____

	No	Yes	If yes, please explain
Any change in insurance?			
Any change in health since last dental visit?			
Any surgeries or hospitalizations since last dental visit?			
Any change in dental health since last dental visit?			
Any new history of cancer or other health issues?			
Are you taking any medications or supplements (prescription and/or non-prescription)?			
Are you allergic to any medications, foods, or latex?			
Do you use any tobacco products?			
Females Only: Are you pregnant?			

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

X_____ X _____

Patient Signature **Date**