Name ____________________
Address ____________________
Home ____________ Cell ____________
Email ____________________
Insurance Update ☐ Yes ☐ No

PATIENT INFORMATION FORM - UPDATE

1 Medical History

Your current physical condition ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one ____________________

____

Have you ever taken Bisphosphonates? ☐ Yes ☐ No

(Known as Fosamax, Actonel, etc.) if yes, when? ____________

FOR WOMEN ONLY

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y	N	Abnormal Bleeding	Y	N	Hemophilia
Y	N	Acid Reflux / Heart Burn	Y	N	Hepatitis
Y	N	Alcohol/Drug Abuse	Y	N	Herpes/Fever Blisters
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV+/AIDS
Y	N	Artificial Bones, Joints or Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Liver Disease
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer/Chemotherapy	Y	N	Osteoporosis
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Care
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Seizures
Y	N	Emphysema	Y	N	Sickle Cell Disease
Y	N	Epilepsy	Y	N	Sinus Problems
Y	N	Fainting Spells	Y	N	Sleep Apnea/CPAP
Y	N	Frequent Headaches	Y	N	Stroke
Y	N	Glaucoma	Y	N	Thyroid Problems
Y	N	Heart Attack	Y	N	Tuberculosis (TB)
Y	N	Heart Surgery	Y	N	Ulcers
			Y	N	Venereal Disease

Please list any medical condition not mentioned above:

____

Have you ever been hospitalized for any reason? Please list why:

____

____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y	N	Aspirin	Y	N	Jewelry/Metals
Y	N	Codeine	Y	N	Latex
Y	N	Dental Anesthetics	Y	N	Penicillin
Y	N	Erythromycin	Y	N	Tetracycline

Please list any allergies not mentioned above:

____

2 Medical Info

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ____________________

____

Physician's Name ____________________

Phone# ____________ Last Visit Date / /

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name ____________ Relation ____________

Home# ____________ Work# ____________

3 UPDATE SIGNATURE

Any changes in your medical history ☐ Yes ☐ No

____
Signature Date

Any changes in your medical history ☐ Yes ☐ No

____
Signature Date

Any changes in your medical history ☐ Yes ☐ No

____
Signature Date

Any changes in your medical history ☐ Yes ☐ No

____
Signature Date