Eleven Eighty Seven Dental Patient Update Form

Name: _____ Date: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Present Employer: _____ Has your insurance changed? _____

Are you currently taking any prescription drugs or over-the-counter medications? YES NO

If YES, please list: _____

Have you ever had an allergic or adverse reaction to any medication or substance? YES NO

If YES, please list: _____

Have you had any surgeries or been hospitalized during the past five years? YES NO

If YES, please explain: _____

Are you pregnant? YES NO Due Date: _____ Are you nursing? YES NO

Circle any condition that you have had in the past or currently have:

Anemia
Arthritis
Artificial Heart Valves
Artificial Joints, Pins, etc.
Asthma
Back Problems
Bleeding Abnormally
Blood Disease
Cancer
Chemical Dependency
Chemotherapy
Circulatory Problems
Congenital Heart Lesions
Cortisone Treatments
Cough Persistent or Bloody
Diabetes
Emphysema
Epilepsy
Fainting
Glaucoma
Headaches
Heart Murmur
Heart Problems
Hemophilia
Hepatitis Type: _____
Hernia Repair
High Blood Pressure
HIV/AIDS
Jaw Pain
Kidney Disease
Latex Allergy
Liver Disease
Low Blood Pressure
Mitral Valve Prolapse
Pacemaker
Radiation Treatment
Respiratory Disease
Rheumatic Fever
Scarlet Fever
Shortness of Breath
Skin Rash
Stroke
Thyroid Problems
Tobacco Habit
Tonsillitis
Tuberculosis

The above information is complete and correct to the best of my knowledge. I understand it is my responsibility to inform my doctor if I or my minor child, have a change in medical history.

Signature: _____ Date: _____