crescentdentalcenter

Medical History Update

Patient Name: _____ **Date:** _____

1. Has there been any change in your contact information, since your last visit? **Yes__ No__**
   If yes, please complete below:

Address	City	State	Zipcode

Cell Phone No.	Home Phone No.	Email

2. Has there been any change of employment, since your last visit? **Yes__ No__**
   If yes, please specify employer's name: _____
   Employer Tel.#: _____ Start Date: _____

3. Have there been any changes in your Dental Insurance, since your last visit? **Yes__ No__**
   If yes, please specify Dental Insurance Name: _____
   Policy No: _____ Coverage Start Date: _____

4. Are you currently attending school? **Yes__ No__**
   If yes, please specify School Name: _____
   Part Time ☐ Full Time ☐

5. Has there been any change in your health, since your last visit? **Yes__ No__**
   If yes, for what condition(s)? _____

6. Have you been hospitalized, since your last visit? **Yes__ No__**
   If yes, for what? _____

7. Are you taking any medications at this time? **Yes__ No__**
   If yes, please list: _____

8. Do you have any allergies (or adverse reactions) to any medications? **Yes__ No__**
   If yes, please list: _____

9. Is there any other conditions that you would like us to know? **Yes__ No__**
   If yes, state: _____

10. Do you or have you taken bisphosphonates? **Yes__ No__**

11. If female: Are you pregnant or think you may be pregnant? **Yes__ No__**
    If yes, when is your due date: _____

Patient Signature: _____ **Dentist Signature:** _____