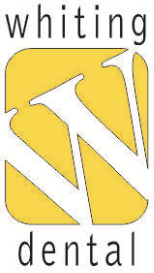

Health History Update

Name_____Date_____

Any changes to address, phone, insurance or email update below: If not state NONE

_____

Do you smoke or chew Tobacco? ____ yes ____ no ___ occasionally

Do your gums bleed easily, feel tender when brushing? ___yes ____no ____occasionally

Are your teeth sensitive to hot, cold, pressure or sweets? ___yes ____no ____occasionally

Do you have a pacemaker? ____yes ____no

Do you have joint replacements? ____yes ____no **if yes, please explain below:**

Which joint? _____ What year? _____

Do you need to take prophylactic antibiotics before dental treatment? _____.

Have you been hospitalized, had surgery or under the care of a medical doctor recently?

If yes please explain? _____

Any Allergies to medications/food? _____

Please list all current medications? Use back of this sheet if needed.

_____
_____
_____

Is there anything else we should know about your medical history?
_____

The previous stated information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____Signature_____