Southern Vista Dental Care

Medical Health Information Update

Patient Name: ______________________________ Date of Birth: ____/____/_____

Personal Information

1. ⌈ Yes ⌈ No: Have there been any changes to your personal information (Phone, Address, Insurance, etc.)?
   If yes, please provide current information:

Home Phone: (   )_____-_______ Cell Phone: (   )_____-_______ Work Phone: (   )_____-_______

Address: ______________________________ City, ST: ____________________ Zip Code: ____________

Email Address: ____

Emergency Contact Name: ____________________ Phone: (   )_____-_______ Relationship to Patient: ______________

Employer: ______________________________

Insurance Company: ______________________ ID #: ______________________ Group#: ______________________

Policy Holder Name: ______________________ Policy Holder SS#: ______________________ Policy Holder DOB: ______________

Medical History

1. Do you currently or have you experienced in the past any of the following: (Please check all that apply)

□ Allergy: medication	□ Excessive bleeding	□ Heart disease	□ High anxiety	□ Stomach Problems
□ Allergy: latex	□ Bruise easily	□ Cancer	□ Mental orders	□ Ulcers
□ Allergy: food/other	□ Liver disease	□ HIV / AIDS	□ Head injuries	□ Cold Sores
□ Artificial joints	□ Kidney disease	□ Hepatitis A, B, or C	□ Dizziness	□ Anemia
□ Heart defect	□ Diabetes	□ Tuberculosis	□ Fainting	□ Current Pregnancy:
□ Heart murmur	□ High blood pressure	□ Asthma	□ Tumors	Due Date ______
□ Pacemaker	□ Chemotherapy	□ Respiratory problems	□ Growths	□ Tobacco use
□ Stroke	□ Radiation treatment	□ Allergy: seasonal	□ Glaucoma	Type __________
□ Rheumatic fever	□ Bone density treatment	□ Nervous disorders	□ Rheumatism	For how long _____

Please comment on any of the above: ____

____

Please list any other medical conditions not listed above: ____

____

2. ⌈ Yes ⌈ No: Are you currently taking bisphosphonates*, (Fosomax, Zometa, Aredia, Pamisol, etc.) for increased bone density?
   Please explain: ____
3. ⌈ Yes ⌈ No: Are you currently taking any blood thinners or anticoagulants (Aspirin, Plavix, Coumadin/Warfarin, etc.)?
   If yes, please explain: ____

Please list any current medications: ⌈ Please check if you have a list (we will be happy to make a copy for our records).

Medication:	Medication is for:
____________________	____
____________________	____
____________________	____
____________________	____

4. Name of primary care physician: ______________________ Date of last examination: ______________________
5. ⌈ Yes ⌈ No: Have you been admitted to a hospital or received emergency care in the last two years?
   If yes, please explain: ____
6. ⌈ Yes ⌈ No: Are you currently receiving medical treatment?
   If yes, please explain: ____

Signature of patient or parent/ guardian:	***Date:***	***Signature of dental professional:***	***Date:***
______________________________	___/___/___	______________________________	___/___/___
______________________________ update	___/___/___	______________________________ update	___/___/___
______________________________ update	___/___/___	______________________________ update	___/___/___