Recall Patient Update Form

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COSMETIC AND FAMILY DENTISTRY

E-mail: Today's Date:

Reset Form

Patient Name: Last First Middle

Home Phone: Include area code ( )

Business/Cell Phone: Include area code ( )

SS# or Patient ID:

Emergency Contact:

Relationship:

Home Phone: ( ) Include area code

Cell Phone: ( )

Have you had active Tuberculosis, persistent cough greater than a three week duration, or a cough that produces blood? ..... Yes ☐ No ☐

If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has your insurance information changed since your last visit? Yes ☐ No ☐

Medical Information

Name of personal physician: Phone:

Date of last visit with your physician:

Current health status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you smoke or chew tobacco? ☐ Yes ☐ No If yes, how often? _____

For women: Are you pregnant? ☐ Yes ☐ No If yes, how many months? _____

Are you currently taking any **Prescription medication**? ☐ Yes ☐ No

Please list: _____

_____

Do you have any **drug allergies**? ☐ Yes ☐ No

Please list: _____

_____

Have you had Botox or Dermal fillers? ☐ Yes ☐ No Are you interested in these services? ☐ Yes ☐ No

Have you had or do you currently have any of the following medical conditions? (Answer all questions)

Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Artificial Heart Valves	☐	☐	Cardiac Transplant
☐	☐	Heart Attack/Stroke	☐	☐	Hemophilia	☐	☐	Joint Replacement
☐	☐	Epilepsy/Siezure	☐	☐	Emphysema	☐	☐	Tuberculosis
☐	☐	Hepatitis/Jaundice	☐	☐	Abnormal Bleeding	☐	☐	Diabetes
☐	☐	Mitral Valve Prolapse	☐	☐	Heart Murmur/Rheumatic Fever	☐	☐	High/Low Blood Pressure
☐	☐	Kidney Problems	☐	☐	Cancer/Chemotherapy	☐	☐	Drug/Alcohol Abuse
☐	☐	Psychiatric Problems	☐	☐	History of Infective Endocarditis	☐	☐	Artificial Limbs
☐	☐	Blood Transfusion	☐	☐	Congenital Heart Transplant	☐	☐	AIDS/HIV

Are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ..... Yes ☐ No ☐

Date Treatment began: _____

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ..... Yes ☐ No ☐

Date: _____ If yes, have you had any complications? _____

Have you ever been treated or hospitalized for any other illness not listed? ☐ Yes ☐ No

If yes please explain: _____

Do you take Antibiotics before dental treatment? ☐ Yes ☐ No

I understand that the information I have provided is correct to the best of my knowledge.

Signature of Patient/Legal Guardian: Date: