ALL Care DENTAL

# Medical history update

FOR A PATIENT WE HAVE SEEN BEFORE

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Your health can change between visits, and what you take changes what is safe to do. This takes about two minutes. A parent or guardian fills it in for a patient under 18.

| OFFICE USE · REVIEWED BY | DATE |
|---|---|
| | |

| PATIENT NAME | DATE OF BIRTH | TODAY'S DATE | DATE OF YOUR LAST VISIT HERE |
|---|---|---|---|
| | | | |

| CELL PHONE | EMAIL | HAS YOUR ADDRESS CHANGED? IF SO, THE NEW ONE |
|---|---|---|
| | | |

## SINCE YOUR LAST VISIT HERE

| | | YES | NO |
|---|---|---|---|
| 1. | Has your general health changed?<br>If yes, please tell us how: _____ | ○ | ○ |
| 2. | Have you started, stopped or changed any medicine?<br>*Include anything bought without a prescription, and vitamins, supplements and herbal remedies.*<br>A _____ B _____ C _____<br>D _____ E _____ F _____ | ○ | ○ |
| 3. | Have you had a new allergy, or a reaction to a medicine?<br>If yes, to what, and what happened? _____ | ○ | ○ |
| 4. | Have you been in hospital, had an operation or been to an emergency department?<br>If yes, when and what for? _____ | ○ | ○ |
| 5. | Are you under the care of a physician or specialist we do not know about? Who, and for what? _____ | ○ | ○ |
| 6. | Have you started a blood thinner, or a medicine for your bones? Which one? _____ | ○ | ○ |
| 7. | Have you had chemotherapy or radiation treatment? | ○ | ○ |
| 8. | Are you pregnant or breastfeeding? If pregnant, when is your baby due? _____ | ○ | ○ |
| 9. | Has your use of tobacco, vaping or cannabis changed? | ○ | ○ |
| 10. | Have you had dental treatment anywhere else since your last visit here? Where? _____ | ○ | ○ |
| 11. | Anything new in your mouth: pain, swelling, a broken tooth, bleeding gums?<br>If yes, please tell us what: _____ | ○ | ○ |
| 12. | Anything else you would like the dentist to know? | | |
| 13. | Has your dental insurance changed? | ○ | ○ |

| NEW INSURANCE COMPANY | GROUP POLICY NUMBER | CERTIFICATE OR ID NUMBER | PLAN HOLDER'S NAME |
|---|---|---|---|
| | | | |

## SIGNATURE

I have read the questions above and my answers are true to the best of my knowledge. I will tell the office if anything about my health changes.

DATE _____ SIGNATURE OF PATIENT, OR PARENT OR GUARDIAN _____

NAME OF PARENT OR GUARDIAN (IF SIGNING FOR A PATIENT UNDER 18) _____ RELATIONSHIP TO THE PATIENT _____

This form holds personal health information. All Care Dental keeps it confidential and uses it to care for you and, when you ask us to, to send claims to your insurer. Please hand it in at the office rather than emailing it.