Established Patient – **Medical History Update**

(use of this form is strictly for subsequent visits within 2 years of original medical history form; A complete medical history form must be on file)

To ensure the highest quality of healthcare, we ask that you complete this patient update form.

Today's Date: ___________/_____________/_________________

Patient Name: ____ Date of Birth: _____________________

Reason for today's visit: __________________________________

Contact information

Email address: ___________________________________ Phone number: ___________________

Address: ____

Preferred method of contact: ________________________

	NO	YES	IF YES, PLEASE EXPLAIN
Any change in health since last dental visit?			
Any surgeries or hospitalizations since last dental visit?			
Any change in dental health since last dental visit?			
Are you taking any medications or supplements (prescription and/or non-prescription)?			
Are you allergic to any medications, foods, or latex?			
Do you use any tobacco products?			
Females only: Are you pregnant?			
Please share any important medical updates not mentioned above:			

I Certify *that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries above can be posed at my appointment. I will not hold the students, faculty, staff or any other member of Clayton State Dental Hygiene Clinic, responsible for any errors or omissions that I have made in the completion of this form.*

X____ X_____________

Signature Date

If this form was completed by someone other than the patient, please include your name and relationship to the patient:

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