Laith Family DENTISTRY

PATIENT UPDATE FORM

Patient Name: _____ **DOB:** _____

Address: _____ **City:** _____

State: _____ **ZIP:** _____ **Mobile Phone: ( ) -** _____

Email: _____

Would you like appointment reminders via: Email Text Phone

Insurance Carrier: _____ **Phone: ( ) -** _____ **New? (Circle) Yes No**

MEDICAL HISTORY

Physician's Name: _____ **Phone: ( ) -** _____

Date of last visit _____ **Currently under physician care? (Circle) Yes No**

Have you had any operations, hospitalizations, or illnesses, for any reason?(Circle) Yes No

Blood transfusion? Date _____ **Taken Fen-Phen/Redux?** _____

Pregnant? _____ **Nursing?** _____ **Taking birth control pills?** _____

Pre-Med? _____ **Joint Replacement?** _____ **Heart Condition?** _____

AIDS/HIV Positive	Y	N	Chemotherapy	Y	N	Spina Bifida	Y	N
Anaphylaxis	Y	N	Circulatory (Heart) Problems	Y	N	Hemophilia	Y	N
Anemia	Y	N	Cortisone	Y	N	Abnormal Bleeding	Y	N
Rheumatism Arthritis	Y	N	Persistent Cough	Y	N	Herpes/ Cold sores	Y	N
Artificial Heart	Y	N	Cough up Blood	Y	N	Hepatitis	Y	N
Ulcer/Colitis	Y	N	Diabetes	Y	N	High Blood Pressure	Y	N
Asthma/Shortness of Breath	Y	N	Epilepsy / Seizure	Y	N	Jaw Pain/ Popping	Y	N
Allergies	Y	N	Fainting	Y	N	Kidney Disease	Y	N
Back Problems	Y	N	Food Allergy	Y	N	Liver Disease	Y	N
Blood Disease	Y	N	Glaucoma	Y	N	Material Allergy (Latex. etc)	Y	N
Cancer/Chemo	Y	N	Headaches	Y	N	Mitral Valve Prolapsed	Y	N
Chemical Dependent	Y	N	Heart Murmur	Y	N	Venereal Disease (Sexually Transmitted Disease)	Y	N
Psychiatric Care	Y	N	Respiratory Disease	Y	N	Pacemaker	Y	N
Rapid weight loss or gain	Y	N	Rheumatic/Scarlet Fever	Y	N	Tonsillitis	Y	N
Radiation Treatment	Y	N	Shingles	Y	N	Tobacco Habit	Y	N
Stroke	Y	N	Surgical Implant	Y	N	Tuberculosis	Y	N
Thyroid Disease/Malfunction	Y	N	Heart Problems/Surgery	Y	N	Alcohol	Y	N
Cholesterol	Y	N	High Blood Pressure	Y	N	Reflux Gastrointestinal	Y	N

Allergic to any medications? _____

Currently taking any medications, vitamins, or herbals? _____

Patient Signature: _____ **Date:** _____