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verobeachdentist.com

2019 Patient Information Update

We appreciate you taking the time to update your records so we can treat all of your dental needs to the best of our ability. Thank you

Patient Name: ______________________________ ____________________ _____ _____________
Last First MI Preferred Name

E Mail Address: ____________________________ Phone Number: _________________________

Address: ____

City ____ State______________ Zip_________________

We communicate with our patients through phone, e-mail and texts. Which method would you prefer?
Check all that apply: ❑Phone Call ❑E mail ❑Text Message

Medical History Update

If you have a list of your current medications we will be happy to make a copy for your chart.

Do you have any CURRENT HEALTH PROBLEMS? ____

What Medications, Vitamins, Herbs, Supplements are you currently taking? ___________________________

____

____

Are you taking or have you taken BISPHOSPHONATES? Boniva, Fosamax Etc. ? ❑ Yes ❑ No

Do you currently use cigars, cigarettes, pipe, or chewing tobacco? ❑ Yes ❑ No

Doctors Name: ___________________________________ Phone: _________________________________

Are you allergic to or have you reacted to any of the following? (Please check all that apply)

❑ Aspirin	❑ Sulfa	❑ Food Allergies	❑ Latex
❑ Metals	❑ Erythromycin	❑ Penicillin	❑ Novocain
❑ Codeine	❑ Nitrous Oxide	❑ Other ________________________	

Medical History

Indicate which of the following conditions you have or have had by checking the box. Check all that apply.

❑ Diabetes, list medication _______________		❑ Non-Insulin Diabetic	❑ Insulin Dependent
❑ Blood Pressure, High	❑ Respiratory Disease	❑ Asthma	❑ COPD
❑ Blood Pressure, Low	❑ Blood Disease	❑ AIDS/HIV	❑ Shortness of Breath
❑ Mitral Valve Prolapse	❑ Dementia/Alzheimer's	❑ Bleeding Disorders	❑ Eating Disorder
❑ Back/Neck Issues	❑ Arthritis	❑ Glaucoma	❑ Pregnant
❑ Thyroid Disease	❑ Kidney Disease	❑ Liver Disease	❑ Acid Reflux
❑ Fainting	❑ Psychiatric Care	❑ Anxiety/Nervous Problems	
❑ Cancer, type/when____________________		❑ Chemotherapy	❑ Radiation
❑ Hepatitis, what type? _________________		❑ TB	Other: ____________

❑ Artificial Joints, what type, when ______________________________ ____________

❑ Heart Problems, please describe ______________________________

❑ Pacemaker/Heart Surgery/ Heart Valve Replacement, what and when ________________________

I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Signature ___________________________________ Date ____________________