MacDonald DENTAL

Established Patient - Dental Medical and History Update

To ensure the highest quality of healthcare, we ask that you complete this patient update form. ***Note:*** **If you have not been seen in our office for over a year, a new complete medical history is required.**

TODAY'S DATE: _____/_____/_____

Patient Name:		**Date of Birth:**
Why are we seeing you today ?	☐ **Follow Up Visit**	☐ **Other: _____**
Preferred Method of Contact: Please provide all methods of contact and then select preferred.		
☐ **Email Address #: _____**	☐ **Home #: _____**	☐ **Cell #:_____**
Home Address:		**Zip Code:**

	NO	YES	IF YES, PLEASE EXPLAIN:
Any changes in Medical Insurance?			
Any changes in Dental Insurance?			

Has there been any change in your health since your last appointment?			
Have you had any Major Health Issues, Surgeries or Hospitilizations since your last visit?			
Has there been any change in your dental health since your last appointment?			
Any NEW family history of cancer or other health issues.			
Are you taking any kind of medications &/or supplements - prescription & /or non-prescription?			
Have you ever taken bisphosphantes, antiresporptive, or antiangiogenic drugs (medicine that effects bone growth or metabolism)?			
Are you Allergic to any medications, foods, or latex?			
Do you use any tobacco products?			

FEMALE ONLY

Are You Pregnant:	☐ ***Yes*** ☐ ***No***
Are You Taking Birth Control	☐ ***Yes*** ☐ ***No***

I Certify *that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.*

X	**X**	**X**	**X**
Signature of Patient (Parent or Guardian if Minor)	**Date**	**Reviewed By Staff (Signature)**	**Date**