

**HEALTH HISTORY UPDATE**

PATIENT'S NAME: \_\_\_\_\_

Date \_\_\_\_\_

Has there been any change in the patient's health since the last dental visit?  Yes  No

For what conditions? \_\_\_\_\_

Is the patient taking any new medications? \_\_\_\_\_ if so, what? \_\_\_\_\_

Have you ever taken or currently take **Bisphosphonate** pills (a drug used for Osteoporosis or similar disease) Yes or No

Any **Allergies?** Yes or No \_\_\_\_\_

Please provide name and phone number of your **Physician:** \_\_\_\_\_

Your **Emergency Contact's** name and phone number: \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Staff Initials \_\_\_\_\_

only if there's a change: Address: \_\_\_\_\_

Contact Phone/s: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date \_\_\_\_\_

Has there been any change in the patient's health since the last dental visit?  Yes  No

For what conditions? \_\_\_\_\_

Is the patient taking any new medications? \_\_\_\_\_ if so, what? \_\_\_\_\_

Have you ever taken or currently take **Bisphosphonate** pills (a drug used for Osteoporosis or similar disease) Yes or No

Any **Allergies?** Yes or No \_\_\_\_\_

Please provide name and phone number of your **Physician:** \_\_\_\_\_

Your **Emergency Contact's** name and phone number: \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Staff Initials \_\_\_\_\_

only if there's a change: Address: \_\_\_\_\_

Contact Phone/s: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date \_\_\_\_\_

Has there been any change in the patient's health since the last dental visit?  Yes  No

For what conditions? \_\_\_\_\_

Is the patient taking any new medications? \_\_\_\_\_ if so, what? \_\_\_\_\_

Have you ever taken or currently take **Bisphosphonate** pills (a drug used for Osteoporosis or similar disease) Yes or No

Any **Allergies?** Yes or No \_\_\_\_\_

Please provide name and phone number of your **Physician:** \_\_\_\_\_

Your **Emergency Contact's** name and phone number: \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Staff Initials \_\_\_\_\_

only if there's a change: Address: \_\_\_\_\_

Contact Phone/s: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date \_\_\_\_\_

Has there been any change in the patient's health since the last dental visit?  Yes  No

For what conditions? \_\_\_\_\_  
\_\_\_\_\_

Is the patient taking any new medications? \_\_\_\_\_ if so, what? \_\_\_\_\_

Have you ever taken or currently take **Bisphosphonate** pills (a drug used for Osteoporosis or similar disease) Yes or No

Any **Allergies?** Yes or No \_\_\_\_\_

Please provide name and phone number of your **Physician:** \_\_\_\_\_

Your **Emergency Contact's** name and phone number: \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Staff Initials \_\_\_\_\_

only if there's a change: Address: \_\_\_\_\_

Contact Phone/s: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date \_\_\_\_\_

Has there been any change in the patient's health since the last dental visit?  Yes  No

For what conditions? \_\_\_\_\_  
\_\_\_\_\_

Is the patient taking any new medications? \_\_\_\_\_ if so, what? \_\_\_\_\_

Have you ever taken or currently take **Bisphosphonate** pills (a drug used for Osteoporosis or similar disease) Yes or No

Any **Allergies?** Yes or No \_\_\_\_\_

Please provide name and phone number of your **Physician:** \_\_\_\_\_

Your **Emergency Contact's** name and phone number: \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Staff Initials \_\_\_\_\_

only if there's a change: Address: \_\_\_\_\_

Contact Phone/s: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date \_\_\_\_\_

Has there been any change in the patient's health since the last dental visit?  Yes  No

For what conditions? \_\_\_\_\_  
\_\_\_\_\_

Is the patient taking any new medications? \_\_\_\_\_ if so, what? \_\_\_\_\_

Have you ever taken or currently take **Bisphosphonate** pills (a drug used for Osteoporosis or similar disease) Yes or No

Any **Allergies?** Yes or No \_\_\_\_\_

Please provide name and phone number of your **Physician:** \_\_\_\_\_

Your **Emergency Contact's** name and phone number: \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Staff Initials \_\_\_\_\_

only if there's a change: Address: \_\_\_\_\_

Contact Phone/s: \_\_\_\_\_ E-mail: \_\_\_\_\_