LV Dental Experts
General/Medical Information Update

Patient Name:_____ Date:_____

Address Change [] Yes [] No If yes, please update:_____

Any Changes to your Insurance? [] Yes [] No If yes, please update:_____

Medical History

Are you under the care of Doctor at this time [] Yes [] No If yes, Why?_____

Doctors Name:_____ Dr's Phone #:_____
Are you allergic to: (**Please Circle)**

Penicillin Codeine Local Anesthetics Sulfa Aspirin Tranquilizers Latex
Other:_____

Are you taking Medication at this time? Including over the counter and Birth Control? If Yes Please list:_____
_____
_____

Women: Are you Pregnant? [] Yes [] No If yes how far along:_____ Are you Nursing? [] Yes [] No
Have you ever been told or taken an antibiotic before dental treatment? [] Yes [] No If Yes, Why?:_____
_____

Do you have or have you had any of the following **(Please check Yes or No):**

Artificial Heart Valve	[] Yes [] No	Aids/HIV	[] Yes [] No	Anemia	[] Yes [] No
Angina	[] Yes [] No	Arthritis	[] Yes [] No	Asthma	[] Yes [] No
Bisphosphonate Therapy	[] Yes [] No	Cancer	[] Yes [] No	Chemo	[] Yes [] No
Bleeding Problems	[] Yes [] No	Diabetes	[] Yes [] No	Dizzy Spells	[] Yes [] No
Drug Addiction	[] Yes [] No	Emphysema	[] Yes [] No	Epilepsy	[] Yes [] No
Fainting	[] Yes [] No	Glaucoma	[] Yes [] No	Hepatitis	[] Yes [] No
Heart Attack/Surgery	[] Yes [] No	Jaundice	[] Yes [] No	Pacemaker	[] Yes [] No
Heart Murmur/Problems	[] Yes [] No	Joint Replacement	[] Yes [] No	Lung Disease	[] Yes [] No
Kidney Disease	[] Yes [] No	Latex Allergy	[] Yes [] No	Liver Problem	[] Yes [] No
High Blood Pressure	[] Yes [] No	Low Blood Pressure	[] Yes [] No	Sinus Trouble	[] Yes [] No
Psychiatric Care	[] Yes [] No	Rheumatic Fever	[] Yes [] No	Sleep Apnea	[] Yes [] No
Thyroid Problems	[] Yes [] No	Tobacco Use	[] Yes [] No	Stroke	[] Yes [] No
TMD or TMJ	[] Yes [] No	Tuberculosis	[] Yes [] No	Venereal Disease	[] Yes [] No

Are there any other health problems not listed, which we should be aware of? [] Yes [] No If yes, explain _____
_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform Dr Chin of any changes in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.

_____ _____
Patient/Parent/Guardian Signature Date

_____ _____
Doctors Signature Date

Medical Update

1. _____ _____ _____
Patient/Parent/Guardian Signature Doctors Signature Date

2._____ _____ _____
Patient/Parent/Guardian Signature Doctors Signature Date

3._____ _____ _____
Patient/Parent/Guardian Signature Doctors Signature Date