Established Patient – Dental Medical and History Update

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Contact Information

Email address:_____

Cell Phone #: _____ Home Phone #: _____

Work Phone #:_____

Address:_____

Preferred method of contact (circle one): ☐ Call ☐ Text ☐ Email

Any changes in your Dental Insurance? ☐ Yes ☐ No
If yes, please provide your current Insurance carrier:_____

Any new allergies since your last visit? ☐ Yes ☐ No
If yes, please list:_____

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_____ _____

Patients Signature Date