



Edward D. Dallam, DDS
Healthy, Ageless Dentistry

Established Patient – Dental Medical History Update

To ensure the highest quality of healthcare, we ask that you complete this patient update form.

Today's Date: ___/___/___
 Patient Name: _____
 Patient Date of Birth: ___/___/___
 Reason for Today's Visit: _____

Contact Information

Email Address: _____
 Phone Number: _____
 Address: _____
 Preferred Method of Contact: _____

	NO	YES	If "YES", PLEASE EXPLAIN
Any changes to your insurance?			
Any changes to your health since last Dental visit?			
Any surgeries or hospitalizations since last Dental visit?			
Any new family history of cancer or other health issues?			
Are you taking any medications or supplements (prescription and/or non-prescription)? <i>If "YES", please list in highlighted field.</i>			
Reason for medication/supplement listed above:			
Are you allergic to any medications, supplements, or latex?			
Do you use tobacco products?			
<i>Females only:</i> Are you pregnant?			
<i>Females only:</i> Are you taking birth control?			

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 staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ Date: ___/___/___
 Patient's Signature

X _____ Date: ___/___/___
 Doctor's Signature