A logo for a dental company

Description automatically generated **Health History Update**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unit/Apt #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have there been any changes to your dental insurance Yes NO If yes, please update below.

**Primary Policy Holder** First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation: \_\_\_\_\_\_\_\_\_\_Gender: **M F** S.S # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Co. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently under the care of a physician? If yes, please complete the line below.** Yes No

Date of Last Visit: \_\_\_\_\_\_\_\_\_\_\_ Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you been a patient in the hospital during the past five years?   Yes       NO**

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Does your physician require you to take antibiotics before a dental visit?**  Yes No

Heart Transplant yes no Nose Obstruction yes no

Artificial Heart Valve yes no Convulsions/Seizure yes no

Lung Disease yes no Neurological Problems yes no

Joint Replacement yes no Kidney Disease yes no

High Blood Pressure yes no Organ Transplant yes no

Heart Condition yes no Osteoporosis yes no

Swollen Ankles yes no Tuberculosis yes no

Arthritis yes no **Allergy/Sensitivity to**:

Anemia yes no Penicillin yes no

Bleeding/Bruising Tendency yes no Erythromycin yes no

Diabetes yes no sulfa yes no

Thyroid yes no Codeine yes no

Ulcer/Colitis yes no Novocain yes no

Herpes yes no Epinephrine yes no

HIV Positive yes no Latex yes no

Hepatitis/Liver Disease yes no other:

Cancer yes no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Radiation yes no

Asthma yes no

Bronchitis yes no

Are you currently taking aspirin, Coumadin or other blood-thinning medication? \_\_\_\_\_\_ yes no

Please list all medications you take, including aspirin, vitamin and supplements:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancellation Policy: If for any reason you can not make your appointment, the office requires a 24 hour notice failure to cancel your appointment in this time frame will result in a cancellation/no show fee that will be applied to your account in the amount of $50.00 first offense and $54.00 for each subsequent missed appointment.

*I hereby authorize release of any information relating to my insurance claim. I understand that I am responsible for all costs of my dental treatment. I authorize payment to the below named dentist of the group insurance otherwise payable to me*.

**Patient/Guardian Signature**: **Date:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Signature**: **Date:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rooted Dental Company PLLC