Patient Medical Update Form

Please complete this update form and return via e-mail at least 24 hours before your appointment.
E-mail to: spartasynergy155@gmail.com
If you are unable to e-mail us the form, please let us know in advance of your appointment. Thank you for your cooperation.

Today's Date:

Name:

Only fill out the sections that have changed.

Address:

City, State, Zip Code:

Home Phone:

Email:

Work Phone:

Can we email or text you to confirm your appointments?
_______Yes _______ No
If yes, *email only* _________ *text only*_________ *both* _________

Cell Phone:

What is the best way to reach you in case of an emergency?

Primary Care Physician Name:

Primary Care Physician Phone:

Pharmacy Name:

Pharmacy Phone:

Emergency Contact Name:

Emergency Contact Phone:

Primary Dental Insurance Company:	**Secondary Dental Insurance Company:**
Subscriber Name:	**Subscriber Name:**
Subscriber DOB:	**Subscriber DOB:**
Subscriber ID:	**Subscriber ID:**
Group Number:	**Group Number:**
Employer:	**Employer:**

Please update the sections of your medical history that have changed.

Y	N	Conditions
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Artificial Bones/Joints
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Back Problems
☐	☐	Bleeding/Clotting Problems
☐	☐	Blood Disease
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Chemical Dependency
☐	☐	Circulatory Problems
☐	☐	Cold Sores
☐	☐	Cough Up Blood
☐	☐	Cough, Persistent
☐	☐	Diabetes
☐	☐	Eating Disorder
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Head/Neck Injury

Y	N	Conditions
☐	☐	Headaches
☐	☐	Heart Murmer
☐	☐	Heart Problems
☐	☐	Hemophilia
☐	☐	Hepatitis
☐	☐	High Blood Pressure
☐	☐	Jaw Pain
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Mitral Valve Prolapse
☐	☐	Nervous Problems
☐	☐	Pacemaker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Respitory Problem
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Shortness Of Breath
☐	☐	Sinus Problems
☐	☐	Steroid Treatments
☐	☐	Stroke
☐	☐	Swollen Feet/Ankles

Y	N	Conditions
☐	☐	Thyroid Problems
☐	☐	Tobacco Habit
☐	☐	Tonsillitis
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

____

____

____

Do you smoke or use tobacco? ___(Y) ___(N)

Women Only

Are you taking Birth Control? ___(Y) ___(N)

Are you pregnant? ___(Y) ___ (N)

If yes, how many weeks?

____

Are you nursing? ___ (Y) ___(N)

PLEASE LIST ALL CURRENT MEDICATIONS & DOSAGES:

Were you advised premedication for dental treatment? If so, please list the prescription below:

Have you had any serious illnesses or operations? ___(Y) ___(N) If yes, please describe:

Signature:

Date: