EMMET DENTAL PC

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MEDICAL BACKGROUND UPDATE FOR RETURNING PATIENTS

Gender: *
☐ Male ☐ Female ☐ Other

Patient Name: _____ * _____ * ___
Last First M

_____
Preferred Name

Family Status: *
☐ Single ☐ Married ☐ Child ☐ Other

Birth Date: * _____

Social Security Number: _____

Email Address: _____

Mailing Adress:

_____

_____

Contact Number: *
○ Mobile Phone:_____ ○ Home Phone:_____
○ Work Phone:_____ ○ Other Phone:_____

Emergency Contact Name and Number: *

_____

_____

Last Dental Examination: _____

Do you have history of any of the following (SELECT ALL THAT APPLY)

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ ?
☐ Allergy - Aspirin	☐ Allergy - Codeine	☐ Allergy - Latex	☐ Allergy - Other
☐ Allergy - Penicillin	☐ Allergy - Sulfa	☐ Allergy -Epinephrine	☐ Allergy -Season/Food
☐ Allergy- Vancocin	☐ Allergy-Motrin/IB	☐ Anemia	☐ Arthritis
☐ Asthma/Bronchitus	☐ Cancer	☐ Cholesterol +	☐ Diabeties
☐ Emphysema	☐ Epilepsy	☐ Glaucoma	☐ Heart Murmur
☐ Hemaphilia	☐ Hepatitus	☐ High Blood Pressure	☐ HIV/AIDS
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Mental Disabilties
☐ Pacemaker	☐ Pregnancy	☐ Radiation Treatment	☐ Rhumatic Fever
☐ Sickle Cell	☐ Sinus Problems	☐ Stent	☐ Stroke
☐ Thyroid +	☐ Tuberculosis	☐ Tumors	☐ Ulcers
☐ Valve prolapse	☐ Venereal Disease		

If currently pregnant, how many weeks or months? (If Applicable)

_____

_____

Medication List (If Applicable):

_____

_____

Pharmacy Name, Number, Address:

_____

_____

Signature: * _____

Date: * _____

Relationship To Patient *
☐ Self ☐ Parent/Legal Guardian ☐ Other

Response Date: _____