PROACTIVE DENTAL

Medical History / Patient Information Update

Patient Name: __________________________ Today's Date: ___________________

HAS YOUR HOME ADDRESS / PHONE CHANGED? YES / NO

Address/City/Zip: ____

Home Phone: _________________________ Cell: _______________________ Work: ____________________

Email Address: ____

HAS YOUR DENTAL INSURANCE CHANGE? YES / NO

Primary Subscriber: ___________________________ SSN / Member ID: _____________________ DOB: ____________

Employer: ____________________________________ Insurance Name: ___________________________________

Insurance Group No: ________________________ Insurance Phone No: ___________________________________

1. Have you had or now have?

Latex Allergy	Yes / No	Seasonal Allergies	Yes / No
Food Allergies	Yes / No		
Drug Allergies	Yes / No	Please List: ____	

1. Are you taking any of the following Medications?

Nerve Pills	Yes / No		
Tranquilizers	Yes / No	Stimulants	Yes / No
Pain Killer	Yes / No	Blood Thinners	Yes / No
Muscle Relaxers	Yes / No	Insulin	Yes / No

Other: ____

2. Do you have any history of Asthma or Breathing problems? Yes / No
   Have you been in the ER for an Asthma attack? Yes / No
   What Asthma medications do you take? ____

3. Please circle the following that apply:

Autism Spectrum	Yes / No	Thyroid Disease	Yes / No	Jaundice/Hepatitis	Yes / No
Sensory Integration Issues	Yes / No	Hearing/Vision Impediment	Yes / No	Prolonged Bleeding	Yes / No
ADD/ADHD	Yes / No	Eating Disorder	Yes / No	Nervousness	Yes / No
Heart Trouble/Murmur	Yes/ No	Abdominal Bleeding	Yes / No	Diarrhea/ Vomiting	Yes / No
Fever	Yes / No	Anesthesia Problems	Yes / No	Mumps Measles	Yes / No
Blood Disease/Anemia	Yes / No	Birth Defects	Yes / No	Cancer/Tumor/Cyst	Yes / No
HIV/AIDS/ARC Virus	Yes / No	Kidney Disease	Yes / No	Sinus Problems	Yes / No
Herpes Virus/ Shingles	Yes / No	Cleft Lip/ Palate	Yes / No	Tuberculosis	Yes / No
Compulsions/Seizures	Yes / No	Scarlet/High Fever	Yes / No	Diabetes	Yes / No
Ear/Nose/Throat Trouble	Yes / No	High/Low Blood Pressure	Yes / No	Leukemia	Yes / No
Stomach Ulcers	Yes / No	Liver Disease	Yes / No	Glaucoma	Yes / No
Heart Surgery/Pacemaker	Yes / No	Severe/Frequent Headache	Yes/ No	Scoliosis	Yes / No

Please list any other Medical Conditions or Surgeries: ____

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