Health History Update

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

Patient's First Name ____

Patient's Last Name ____

Today's Date: ____

Contact Information

Phone #: ____

Email Address: ____

Street Address 1: ____

Street Address 2: ____

Emergency Contact: ____

Street Address 1: ____

Phone Number: ____

Any Changes in Insurance?

Yes ☐ No ☐

Policy Holder Name: ____

Subscriber ID #: ____

Subscriber Date of Birth: ____

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EMAIL: INFO@SOUTHERNROOTSPERIO.COM

Group Number: ______________________________

Relationship to subscriber: ______________________________

Any changes in dental health since your last visit?

Yes
No

If yes, please explain: ______________________________

Any surgeries, hospitalizations, disease/condition diagnoses, or other changes in general (medical) health since my last dental visit?

Yes
No

If yes, please explain: ______________________________

Do you have, or have you ever had, any of the following conditions?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches

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- Glaucoma
- Hay Fever
- Head Injuries
- Hearing Impairment
- Heart Attack/Failure
- Heart Murmur
- Heart Pacemaker
- Heart Trouble/Disease
- Hemophilia
- Hepatitis A
- Hepatitis B or C
- Herpes
- High Blood Pressure
- High Cholesterol
- Hives or Rash
- Hypoglycemia
- Irregular Heartbeat
- Kidney Problems
- Leukemia
- Liver Disease
- Low Blood Pressure
- Lung Disease
- Mitral Valve Prolapse
- Osteoporosis
- Pain in Jaw Joints
- Parathyroid Disease
- Bisphosphonate Treatment
- Radiation Treatments
- Recent Weight Loss
- Renal Dialysis
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Shingles
- Sickle Cell Disease
- Sleep Apnea
- Spina Bifida
- Stomach/Intestinal Disease
- Stroke
- Swelling of Limbs
- Thyroid Disease
- TMJ
- Tonsillitis
- Tuberculosis
- Tumors or Growths
- Ulcers
- Vision Loss/Blindness
- Yellow Jaundice

Are you taking any prescription medications?

Yes If yes, please explain: ____
No

Are you allergic to any of the following?

- Acrylics
- Antibiotics
- Aspirin
- Codeine
- Iodine
- Latex

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- ☐ Local Anesthetics
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ Other
- ☐ None

Has your General Dentist, Physician, or Therapist changed?

Yes ____

No

Do you use any tobacco or marijuana products or other controlled substances?

Yes
No

If yes, please explain: ____

For Women Only

Are you pregnant?

Yes
No

Are you taking birth control?

Yes
No

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

Patient's Name ______________________________________

Patient's signature ______________________________________ Date: ________________