

MEDICAL HISTORY UPDATE

PATIENT NAME _____	TELEPHONE _____
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MEDICAL HISTORY UPDATE

Date _____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any kind of medication at this time? Yes No

If so, what _____

Do you have any allergies (or adverse reactions) to any medications? Yes No

If so, what _____

Patient Signature

Doctor Signature

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