Dr. William Moore
General Dentistry

PATIENT INFORMATION

Date					
Name		Home Phone			
Street Address		Cell Phone			
City		State		Zip	
Date of Birth		SSN		Gender	
Email					
Emergency Contact Name		Phone			
Has the responsible party changed?	☐ No	☐ Yes _____			

REVIEW OF THE PATIENT'S MEDICAL HISTORY

1. Has there been any change of general health status?	☐ NO CHANGE
2 Is there any health problems of with you wish to make us aware of?	
3. List any allergies:	
4. List **ANY** drugs or medicines that you are currently taking	☐ Check box if providing a medication list today

DRUG	DOSAGE / HOW OFTEN	HOW LONG	PRESCRIBER

5. Have you ever been advised NOT to take a medication?	☐ No	☐ Yes _____
6. Have you been advised to pre-med before dental procedures?	☐ No	☐ Yes _____
7. Are you currently taking blood thinners?	☐ No	☐ Yes _____

IMPORTANT: Have you ever been treated for **Osteoporosis or Osteopenia?** If yes, please check:

☐ ACTONEL	☐ FOSAMAX	☐ BONIVA	☐ ZOMETA	☐ SKELID	☐ OSTAC	☐ BONEFOS	☐ DIDRONEL

Physician		Last Seen / Reason	
Person completing this update (please print):			
Relationship to Patient:			
Signature:			