



Date: _____

Medical Update

Name: _____ Date of Birth: _____

Home Number: _____ Mobile Number: _____

Work Number: _____ Email: _____

Preferred Contact: Home Work Cell Email

Home Address: _____ Apt# _____

City: _____ State: _____ Zip Code: _____

Dental

Are you currently having any tooth or jaw pains? _____ Yes No
 Do your gums bleed when you brush or floss? _____ Yes No
 Does food get caught between your teeth
 or is it difficult to floss any area of your mouth? _____ Yes No
 Would you like whiter teeth? _____ Yes No
 Would you like straighter teeth? _____ Yes No
 Would you like to see what a smile makeover
 would look like on you through digital imaging? _____ Yes No

Medical

Are there any changes in your medical history? _____ Yes No
 If yes, please note: _____
 Are you taking new medications? _____ Yes No
 If yes, please note: _____
 Do you have medical allergies? _____ Yes No
 Have you had a serious illness or operation within the last year? _____ Yes No
 If yes, please note: _____
 Do you require premedication? _____ Yes No
 If yes, please note: _____

Patient Signature: _____ Date: _____