DIAMOND DENTAL
as distinctive as you are

Medical History Update Form

Today's Date: _____/_____/_____

Patients Name: _____ Date of Birth: _____

Any changes in insurance? Circle one: Yes or No If yes, please provide information below:

_____

_____

Any changes in health since last dental visit? If yes, please provide information below:

_____

_____

Any surgeries or hospitalizations since last dental visit? If yes, please provide information below:

_____

_____

Are you taking any medications or supplements (prescription and / or non-prescription)?
If yes, please provide information below:

_____

_____

_____

Are you allergic to any medications, food, or latex? Circle one: Yes or No If yes, please provide information below:

_____

_____

_____

- ★ Females only: Are you pregnant? Yes or No
- ★ Females only: Are you on birth control? If yes please provide information below:

  _____

  _____

Patient Signature: _____