WINTER

winterdds.net

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REGISTRATION & TREATMENT UPDATE

Date:_____

Please indicate if there are any changes in your personal or health information. ☐ No changes ☐ Changes as indicated.

Patient Information

Name change:_____
Last First MI

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____ Cell:_____

Email:_____

☐ Married ☐ Single ☐ Divorced ☐ Separated New Spouses/ SO Name:_____

Emergency contact:_____ Phone: _____

Family Physician:_____ Specialty:_____ Date of Last Visit:_____

Medical History

1. Are there any changes in your medications since your last appointment (including over the counter medications, vitamins, other recreational drugs or supplements)? ☐ No ☐ Yes If yes, list_____
2. Do you have any new allergies? ☐ No ☐ Yes List: _____

   Please describe the reaction (hives, difficulty breathing, etc.):_____

Please read the following list carefully. If you have any of the following, please check or indicate the problem, disorder, or disease and list below.

☐ Cardiovascular (heart/circulatory) problems or diseases
☐ Respiratory problems or diseases
☐ Endocrine (hormonal) disorders or diseases
☐ Kidney or liver disorders
☐ Musculoskeletal (bone or joint) disorders or problems
☐ Mental health issues or problems including eating disorders
☐ Need pre-medication for dental work
☐ Neurological problems or diseases
☐ Blood conditions or positive HIV status
☐ Intestinal or stomach conditions
☐ Glaucoma or vision problems
☐ Cancer or Tumor growth
☐ Artificial implants
☐ Pregnant or possibly pregnant
☐ Other: _____
_____
_____

☐ Medically prescribed diet – Please explain:_____

☐ Been hospitalized for a serious injury or illness: Please explain:_____

Please list: _____

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at the time of my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is given for the dental treatment to be rendered by the dentist and office staff, and I will assume financial responsibility for all treatment provided.

Signature:_____ Date:_____

If patient is under 18 or has been declared incompetent:

Parent/Guardian Signature:_____ Date:_____

Relationship:_____