Medical History Update

Name: _____

Date of Birth: _____

Contact Information

Address	Phone number
	Email address

Emergency Contact

Name	Relationship	Phone number

Medical Information

Physician name	
Date of last physical exam	Office phone
Preferred pharmacy	Pharmacy phone
General dentist	Dentist phone
Has there been any change in your general health within the last year? □Yes □No If yes, what condition is being treated?	
Have you had a serious illness, operation, or been hospitalized in the past 5 years? □Yes □No If yes, please describe.	
List all prescribed and over-the-counter medications with their doses. _____ _____	
Have you been vaccinated against COVID-19? □Yes □No	

The information I have provided is correct to the best of my knowledge. If changes occur (ie. Modification in prescriptions, new diagnoses or surgeries), I will notify Fay Periodontal Associates. I understand the importance of a truthful health history, including medication use, and that my dental team will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Fay Periodontal Associates responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____