WESTFALL DENTAL GROUP
GENERAL DENTISTRY

Updated Health Information

Emergency Contact ___________________________

Phone # ___________________________

Name ___________________________ Date of Birth ______________ Today's Date ______________

Have you ever had or are you currently being treated for any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies
  - Food ______________
  - Medicine ______________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
  - Date: ______________
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
  - Type ______________
  - Date ______________
- ☐ Chemo Therapy
  - Date: ______________
- ☐ Crohns Disease
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting and Seizures
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Glaucoma
- ☐ Gluten Free/Celiac Dis.
- ☐ H.I.V. Positive
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnant: Yes / No
  - Due Date ________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ STD
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ TMJ
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Conditions not listed
  - ______________
  - ______________
  - ______________
- ☐ Do you wear removable appliances? Y ____ N_____

Is antibiotic pre-med required? ______________

Please list all current medication and herbal remedies: ___________________________

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Pharmacy: Name ______________ Location ______________ Phone # ______________

Do your gums bleed when you brush? ☐ Yes ☐ No ☐ Don't know

Are your teeth sensitive to cold, hot, sweets or pressure? ☐ Yes ☐ No ☐ Don't know

Do you have headaches, earaches or neck pains? ☐ Yes ☐ No ☐ Don't know

How do you feel about the appearance of your teeth? ___________________________

Name of Physician ___________________________ Phone ______________

Name of Specialist ___________________________ Phone ______________

All of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

___________________________ Date ______________

Signature of Patient, parent or guardian