



Information Update:

In order to allow us to continue to providing you with the best care possible please take a moment and fill out the following information.

Name: _____

Medications: Please list all the medications you are currently taking:

Are you currently taking any **blood thinners**? _____

Are you currently taking any **osteoporosis** medications? _____

Please list any **allergies** you have: _____

Medical History: Please **list and date** any recent serious illnesses or operations.

Thank you for keeping us informed of any changes that may occur to your health history

* * * * *

Please update your contact information

Address: _____

Phone Number: _____

Email Address: _____

Name of current dental insurance provider: _____

Patient Signature

Date