Health History Update Form

Today's Date

PATIENT INFORMATION

Patient Name

Date of Birth

Mailing Address

City

State

Zip

Phone #

Email Address

MEDICAL INFORMATION

Are there any changes in your health?

Yes No

If so please specify

Physician's Name

Physician's Phone #

Are you allergic to Latex?

Yes No

Do you need to be premedicated?

Yes No

SIGNATURE

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

☐ I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my doctor and their staff 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 my doctor, or any other member of their staff, 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.

Name of Patient/Legal Guardian

Signature of Patient/Legal Guardian

Date