Medical History Update Request

Update Home Address:

Address:_____

City:_____ **State:**_____ **Zip:**_____

Are you currently under physician care? □ Yes □ No If yes, describe:

_____

Physician's name _____ City _____ State _____ Phone _____

Date of last visit _____ Have you ever had any serious illnesses or operations? □ Yes □ No

If yes, describe:

_____

Have you ever had a blood transfusion? □ Yes □ No

If yes, give approximate dates _____

Women: Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Check (X) if you have had any of the following:

□AIDS/HIV Positive
□Anaphylaxis
□Anemia
□Arthritis, Rheumatism
□Artificial heart valves
□Artificial joints
□Asthma
□Atopic (allergy prone)
□Back problems
□Blood disease
□Cancer
□Chemical dependency
□Chemotherapy
□Circulatory problems
□Cortisone treatments
□Cough, persistent
□Cough up blood
□Diabetes
□Epilepsy
□Fainting
□Food allergies
□Glaucoma
□Headaches
□Heart murmur
□Heart problems
_____
□Hemophilia
□Herpes
□Hepatitis
□High blood pressure
□High Cholesterol
□Kidney disease
□Liver disease
□Material allergies (latex wool, metal, chemicals)
□Mitral valve prolapse
□Nervous problem
□ Osteoporosis
□ Pacemaker/Heart surgery
□ Psychiatric care
□ Radiation treatment
□ Respiratory disease
□Shingles
□Shortness of breath
□Skin rash
□Spina Bifida
□Stroke
□Surgical implant
□Swelling of feet or ankles
□Thyroid disease or malfunction
□Tobacco habit
□Tuberculosis
□Ulcer/Colitis
□Venereal disease

List medications you are currently taking, if any:

_____

List drug allergies, if any:

_____

People with whom we can discuss your healthcare:

Name:_____ Relationship:_____ Contact No._____

Name:_____ Relationship:_____ Contact No._____

To the best of my knowledge the questions of this form has been accurately answered. The undersigned hereby authorized the Doctor and/or Dental Staff to perform all the necessary and advisable diagnosis and treatment procedures deemed appropriate to make a thorough diagnosis and treatment of the above-named patient's dental oral-facial needs including X-rays, study models, photographs, surgical procedures, and the use of local anesthetics agents and medications. I also authorize the Doctor and/or Dental Staff to release and to request medical information to and from any medical/dental professional facilities and my insurance company. I agree to be responsible for payment of all services rendered on my behalf or my dependents in the form of cash, check, credit card or outside financial resources. I also understand that payment is due in full prior to reserving time in the schedule for any prescribed treatment. **This office is being secured with ADT.

IT IS IMPERATIVE THAT YOU ACTIVELY PARTICIPATE IN YOUR TREATMENT AND APPOINTMENT PLANNING. Appointments with Dr. Sadati missed or cancelled with less than 2 business days are subject to be charged at $600.00 per hour and Hygiene appointments will be charged according to the treatment scheduled for that day and time.

PATIENTS SIGNATURE _____ **Phone #** _____**DATE**_____

PRINT NAME :_____ **EMAIL ADDRESS** _____

DOCTORS SIGNATURE : _____ **DATE:** _____