KATY TRAIL DENTAL

Health History Update

Patient Name: _____ Date of Birth: _____

Has there been a change in your health since we last saw you? (i.e under the care of a physician, pregnant or trying to get pregnant) Yes ☐ No ☐

If yes, please explain: _____

_____

Have you been hospitalized since your last appointment? Yes ☐ No ☐

If yes, please explain: _____

_____

Are you taking any medication at this time? Or new supplements? Yes ☐ No ☐

If yes, what? _____

_____

_____

Do you have any allergies or adverse reactions to any medications? Yes ☐ No ☐

If yes, what? _____

_____

Are there any changes in your dental insurance? Yes ☐ No ☐

If yes, what? _____

Are you interested in Veneers? Yes ☐ No ☐

Are you interested in Botox? Yes ☐ No ☐

Are you interested in Invisalign? Yes ☐ No ☐

Are you interested in/do you need a nightguard? Yes ☐ No ☐

Are you interested in in-office Whitening or refillable whitening trays? Yes ☐ No ☐

Do you need extra toothbrush heads for Sonicare? Yes ☐ No ☐

UPDATED ADDRESS (Or FORWARDING ADDRESS if moving. It is <u>YOUR</u> responsibility to update your address in the event of a move.):

_____

Patient's Signature: _____ Date: _____

Clinician's Signature: _____

Doctor's Signature: _____