Scott C. Kogler, DDS

Revised 11/2009

INFORMATION & MEDICAL HISTORY UPDATE

Today's Date_____

Patient's Name_____ SS#_____ Date of Birth_____

Patient's Current Address_____

_____ e-Mail Address_____

Patient's Current Home Phone No._____ Work No._____ Cell No._____

Patient's Current Dental Insurance Coverage_____

Has your dental insurance recently changed? ☐No ☐Yes If yes, complete information below:

Insured's Name:_____ Insured's Date of Birth:_____

Insured's Employer:_____ Insured's SS#_____ Group #_____

1. Are you under the care of a physician now? ☐Yes ☐No

   If yes, Physician's Name_____

   Reason for medical care_____

2. List all medication you are currently taking:

Medication	Reason

3. Are you allergic to any drugs? ☐ Yes ☐ No

   If yes, please list_____

4. List any changes in your health_____

5. Are you having any dental problems now? ☐ Yes ☐ No

   If yes, please describe_____

6. Would you like to know what options are available to you to create a more attractive smile? ☐ Yes ☐ No

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS

	Circle	
Artificial Heart Valve	Yes	No
Prosthetic Joint Replacements	Yes	No
High Blood Pressure	Yes	No
Mitral Valve Prolapse	Yes	No
Abnormal Bleeding or Anemia	Yes	No
AIDS (HIV Positive)	Yes	No
Heart Murmur	Yes	No
Women: Are you pregnant?	Yes	No
Latex Allergies	Yes	No

	Circle	
Pacemaker	Yes	No
Rheumatic Fever	Yes	No
Kidney Disease	Yes	No
Hepatitis	Yes	No
Diabetes	Yes	No
Tumors or Growths	Yes	No
Epilepsy/Seizures	Yes	No

If yes, what is your due date? _____

Signature_____(Guardian if under 18)

FOR OFFICE USE ONLY: **The above information has been reviewed by:**_____ **Date:**_____