QUALITY CARE DENTAL ☺ Taub and Lewis DDS ☺ 300 S. LITTLE TOR ROAD ☺ NEW CITY, NY 10956-1444 ☺ 845-634-9155

PATIENT MEDICAL HEALTH UPDATE ***PLEASE COMPLETE ENTIRE FORM***

Print Name: _____

Address: _____

Home, Cell , Work #: _____

E-mail address: _____

WHAT IS THE BEST WAY FOR US TO CONTACT YOU? _____

MAY WE CALL AT WORK TO SCHEDULE AND/OR CONFIRM APPTS ? YES___NO___

MAY WE LEAVE DETAILED MESSAGES ON YOUR VOICE MAIL? YES ____ NO ____

1. ARE YOU TAKING ANY **MEDICATIONS** REGULARLY? NO _____
   YES - LIST:_____

2. ARE YOU **ALLERGIC** TO ANY **MEDICATIONS** OR **LATEX**? NO _____
   YES - LIST:_____

3. IS YOUR **BLOOD PRESSURE** NORMAL? YES _____ NO _____

4. DO YOU HAVE ANY **HEART CONDITION**, INCLUDING MVP (MITRAL VALVE PROLAPSE), DAMAGED VALVES, MURMUR? NO _____
   YES - LIST:_____

5. DO YOU HAVE ANY **ARTIFICIAL JOINTS** (HIP, KNEE ETC.)? NO _____
   YES - LIST:_____

6. DO YOU NEED TO **PREMEDICATE** BEFORE DENTAL TREATMENT? YES ____ NO _____

7. DO YOU HAVE **DIABETES**? YES _____ NO _____

8. DO YOU **SMOKE**? YES ____ NO ___ IF EVER, WHEN DID YOU STOP? _____

9. ARE THERE ANY OTHER **CHANGES** IN YOUR HEALTH SINCE YOUR LAST VISIT TO THIS OFFICE? NO _____ YES - LIST:_____

10. ARE THERE ANY **COSMETIC OR FUNCTIONAL** PROBLEMS WITH YOUR TEETH?
    NO _____ YES - LIST:_____

11. HAS YOUR **INSURANCE** INFORMATION CHANGED? YES _____ NO _____

SIGNATURE: _____ ***DATE:***_____

Have you received a copy of our Notice of Privacy Practices? YES____ NO____ Received at this visit _____