# Recall Update Form

Name of patient________________________ Date______________

Address ____________________________ Phone______________

Cell Phone #______________________________________________

City, State, Zip____________________________________________

Insurance Co. Name_________________________________________

Employer Name______________________ Phone______________
Medical Doctor's Name (not your dentist) ________________________

1. Are you currently having any problems with your teeth or gums? ..Y N
2. Are you in good health? ................................................Y N
3. Have there been any changes in your health within the last year? ...Y N
4. Are you presently under the care of a physician? ......................Y N
   Date of your last physical exam____________________________
5. Are you taking ANY medicine at the present time? ...................Y N
   If yes, please list___________________________________________
   _____________________________________________________________
6. Are you **allergic** to any medication? .......................................Y N
   If yes, what? _______________________________________________
   _____________________________________________________________
7. Do you have **mitral valve prolapse**? .......................................Y N
8. Do you have a **heart murmur**? ..............................................Y N
9. Do you have a knee or hip replacement or other prosthesis? ..........Y N

10. Has there been any change to your dental insurance? ...............Y N
11. Do you smoke or use tobacco? ..........................................Y N
12. Do you have a latex allergy? ............................................. Y N
13. Have you ever taken any of the following appetite suppressants: Y N
    Fenfluramine (Pondimin), Dexphenfluramine (Redux), either alone or in combination with phentermine (commonly known as fen-phen)
14. Have you ever taken Fosamax, Actonel, Aredia, Zometa, Boniva? Y N

**Women only:**

15. Are you pregnant? ...................................................... Y N
    If yes, due date: ______________________________

Signature ______________________________ Date______________

Emergency Contact:__________________________Phone______________