PARKWAY DENTAL – MEDICAL UPDATE

NAME: DATE:

Since the last time you were at Parkway Dental…
Have you been hospitalized or had surgery? _____
Have you had any changes in your health? _____
Allergic to any new medications? _____
Taking new medications? (if yes, please list medications)_____
_____

Have you had any of the following: Congenital Heart Defects, Artificial Valves, Joint Replacements?_____

***Females Only*:** Are you pregnant? ☐ YES ☐ NO If yes, which trimester? _____

Patient's Signature: _____

Employee's Signature: _____

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