

Health History Update

Amit Shah, DDS
Creating Healthier Smiles

Today's date _____

Patient Number _____

First name _____

Middle initial _____

Last name _____

Address _____

City _____

State _____ ZIP _____

Home phone (____) _____ - _____

Work (____) _____ - _____

Cell (____) _____ - _____

E-mail _____

Fax (____) _____ - _____

Anything else we should know? _____

Health changes since last visit:

Date health change occurred _____

Physician's name _____ Physician's phone _____

Current medications

Last physical exam _____ Any allergies? _____

Patient signature _____ Staff initials _____ Date _____

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Date health change occurred _____

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Patient signature _____ Staff initials _____ Date _____