ED FRANCISCO DDS, PA
Patient Information Update

Patient Information:

Name _____
Address _____
City _____ State _____ Zip Code _____
Cell (_____) _____ Home (_____) _____Work (_____) _____
Email _____
Emergency Contact _____ Relationship _____ Phone (_____) _____
Do you have any changes to your dental insurance coverage? Yes / No
If yes, please provide details _____

Medical and Dental History:

Have you been hospitalized for any surgical operations or serious illness in the past year? Yes / No
If yes, please explain _____
Are you currently taking any medication(s) including non-prescription medicine? Yes / No
If yes, list medication and dosage _____
Do you have any health problems from last year that need further clarification? Yes / No
If yes, please explain _____
Have you ever taken any of the following (circle yes / no):

1. Fen-Phen/Redux Yes / No
2. Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? Yes / No
3. Viagra, Revatio, Cialis or Levitra in the last 24 hours? Yes / No
4. Do you use controlled substances? Yes / No
5. Do you smoke, chew tobacco, or vape? Yes / No

Are you allergic to or have you had any reaction to the following medication (circle yes / no):

• Local Anesthetics	Yes / No	• Penicillin, Tetracycline, or any other antibiotic	Yes / No
• Sulfa Drugs	Yes / No	• Aspirin	Yes / No
• Codeine	Yes / No	• Metal	Yes / No
• Sedatives	Yes / No	• Latex	Yes / No
• Iodine	Yes / No	• Other (please list) _____	

Medical Conditions (please circle any of the following that you have had or currently have):

• Allergies (pollen, dust)	• Drug Addition	• HIV/AIDS (circle)
• Anemia	• Emphysema	• Human Papillomavirus HPV
• Angina/Chest Pain	• Epilepsy/Convulsions	• Kidney Disease
• Anxiety/Nervous Disorder	• Excessive/Abnormal Bleeding	• Liver Disease
• Arthritis/Gout	• Excessive Thirst	• Mitral Valve Prolapse
• Artificial Heart Valve	• Fainting/Seizures	• Nursing
• Artificial Joint	• GI Disorders/Acid Reflux	• Pneumonia
• Asthma	• Glaucoma	• Pregnant or Attempting
• Blood Pressure Low	• Heart Attack/Failure	• Taking Oral Contraceptives
• Blood Pressure High	• Heart Disease	• Thyroid Problem
• Bone Disorders	• Heart Murmur	• Tuberculosis
• Cancer	• Heart Pace Maker	• Weight Loss (unexpected)
• Chemotherapy/Radiation	• Hepatitis A, B, C (circle)	• Other _____
• Diabetes	• Herpes Simplex Type I	_____

To the best of my knowledge and belief, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at my next appointment.

Patient or Parent/Guardian Signature_____ Date _____

Doctor/Hygienist Signature_____ Date _____