PREMIER DENTISTRY

Name: ______________________________ **Date of Birth:** __________________

Address:____

Home Number: __________________ **Cell Number:** ____________________

Has your dental coverage changed? ___ **Yes** ___ **No**

If your insurance has changed, please provide us with a copy of your identification card and or the following information:

- **Identification number:** _________________________
- **Insurance company telephone number:** ______________________

Medical History Update

1. **Has there been any change in your health since your last dental appointment?**

   ___ **Yes** ___ **No**
2. **If so, please describe** ____
3. **Are you taking any medications?** _______________________________________
4. **If so, please list medication and dosage:** ______________________________
5. **Have you developed any new allergies or sensitivities?** ____ **Yes** ____ **No**
6. **If so, what (i.e. Medications, latex, metals)**

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