RICHARD GOTTLIEB, DMD

MEDICAL HISTORY UPDATE

Name: _____

Home Address: _____

City/State: _____Zip Code: _____Email: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

1.) **Has your Dental Insurance changed?**

2.) **In the last 6 months, have you had any of the following:**
COVID-19 Pacemaker Stroke Heart Attack Stents

3.) **Please circle any condition you have or ever had:**

Artificial Joint	Epilepsy	HIV
Asthma/COPD	Heart Disease	Kidney Disease/Dialysis
Covid-19	Hepatitis	Osteoporosis
Diabetes	High Blood Pressure	Sleep Apnea

4.) **Have you ever been advised to "Pre-Medicate" with antibiotics prior to having dental work performed? _____** If yes, please list the medication, dosage and pharmacy:
_____

5.) Are you taking any medications, such as **blood thinners, or those to treat osteoporosis**? If yes, please list and give reason:
_____

6.) Are you taking any other medications? If yes, please list and give reason:

_____

_____

7.) Drug/Food Allergies: _____

8.) Emergency contact information: _____

Any information in your medical health can dictate the course of your treatment. I will not hold my dentist or any member of his staff responsible for any errors or emissions that I may have made in the completion of this form.

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Signature Date