PATIENT NUMBER

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(800) 243-4675

PATIENT'S NAME _____
Last First Initial Date of Birth

I understand that medical conditions and medications can affect dental treatment. I agree to notify my dentist of any changes in medical history or condition.

DATE	CHANGE IN MEDICAL HISTORY OR MEDICATION	DENTIST'S SIGNATURE	PATIENT'S SIGNATURE

ANEST.

MED. ALERT

Form No. T145MHU

MEDICAL HISTORY UPDATE FORM