PATIENT MEDICAL HISTORY ACKNOWLEDGEMENT

Date:______________________

I have reviewed the attached MEDICAL HISTORY. My general health status, medication and/or medical provider has changed as follows (if no change, write "NO CHANGE"):

____

____

I understand that should there be a change in my health during my dental treatment, I am to inform the dentist at the earliest possible time.

Person Completing the Update: Signature____

Print Name ____

If other than the patient, indicate relationship:____

Update reviewed by Dr. ____

Date:______________________

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