Hudson Highlands Dentistry LLC
JOHN T. LYNCH, DMD

MEDICAL INFORMATION UPDATE

*required field

*Date _____

*Patient Name _____ *Date of Birth _____

If Parent/Guardian is submitting this, please provide your info as follows:

Parent/Guardian Name: _____
Phone: _____ E mail: _____
Signature: _____

Please update us with any new information regarding your medical condition. This would include any of the following:

- New diagnosis
- Medical treatment and/or surgery
- Hospitalizations
- New medications including strengths and dosages
- Medications that have been discontinued or modified
- Change in primary physician or their contact information
- Specialist added as a caregiver (i.e.- cardiologist, oncologist, etc.)

_____
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_____

Signature (Patient/Guardian) _____

MEDICAL HISTORY UPDATE FORM

C 2005 Wisconsin Dental Association
(800) 243-4675

Hudson Highlands Dentistry LLC
JOHN T. LYNCH, DMD

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

MEDICAL HISTORY UPDATE FORM