



BROADVIEW
— D E N T A L —

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101 W Broad Street Suite 200

Falls Church, VA 22046

Health History Update Form

Patient Information:

Patient Name: _____ Preferred Name: _____

If Child, Parent/Guardian Name(s): _____

Date of Birth: _____

Contact information:

Has your contact information changed? ☐ Yes ☐ No

If yes, update below:

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

Has your emergency contact changed? ☐ Yes ☐ No

If yes, update below:

Emergency Contact: _____ Phone: _____

Relationship to the Patient: _____

Medical History:

Have you had any changes to your?

- ☐ Medical Conditions
- ☐ Medications
- ☐ Allergies
- ☐ Surgeries or Hospitalizations
- ☐ Pregnancy Status
- ☐ No Changes

If yes, please explain: _____

Dental History:

Since your last visit, have you experienced any of the following?

- ☐ Tooth Pain
- ☐ Broken Tooth
- ☐ Swelling
- ☐ Bleeding Gums
- ☐ Sensitive Teeth
- ☐ Jaw Pain
- ☐ Clenching/Grinding
- ☐ Dental Treatment at Another Office
- ☐ None of the Above

If yes, please explain: _____

Acknowledgment

I certify that I have reviewed my information and that the information provided is complete and accurate to the best of my knowledge. I understand that it is my responsibility to notify Broadview Dental of any changes to my medical history, medications, allergies, insurance information, or contact information.

Patient/Guardian Signature: _____ Date: _____