



CHRISTINA GREENE  
FAMILY DENTISTRY

**UPDATED HEALTH HISTORY**

Have there been any changes in your health since your last dental appointment? \_\_\_\_\_

If so, please explain:

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Are you taking any new medications?

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Any changes in your address or contact information?

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Any additional concerns that we should be made aware of?

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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_