Medication List

Patient Name: _____ Birth Date: _____

List all medications & what they are taken for:

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Please use the area below to list and describe any additional medical conditions, hospitalization, major medical treatment, etc… that you have not addressed on the previous medical history form:

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Signature: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature: _____ **Date**_____

(Parent or guardian to sign if patient is under 18 years of age)