Dentistry at South Brunswick MEDICAL HISTORY UPDATE

Patient Name: _____ **DOB:** _____

Address: _____ **City:** _____ **Zip Code:** _____

Phone #: _____ **Email:** _____ **Work #:** _____

Has your insurance changed in the last year? [ ] Yes [ ] No

If yes, please provide the new insurance card to front desk!

MEDICAL/DENTAL HISTORY - Have you ever had any of the following? (Check the boxes that apply)

[ ] Heart Problems	[ ] Back Problems	[ ] Oral Herpes	[ ] Sinus Problems
[ ] High Blood Pressure	[ ] Diabetes	[ ] Allergies to Anesthetics	[ ] "AIDS" or other immune disorders
[ ] Low Blood Pressure	[ ] Respiratory Disease	[ ] Blood Disease	
[ ] Pacemaker	[ ] Epilepsy	[ ] Arthritis	[ ] Special Diet
[ ] Nervous Problems	[ ] Headaches	[ ] General Allergies	[ ] Stroke
[ ] Heart Murmur	[ ] Hepatitis	[ ] Allergies to Medicine/Drug	[ ] Ulcer
[ ] Artificial Heart Valves	[ ] Jaundice/Liver Disease	[ ] Radiation Treatment	[ ] Venereal Disease
[ ] Artificial Joints	[ ] Chemical Dependency	[ ] Swollen Neck Glands	[ ] Cancer
[ ] Recent Weight Loss	[ ] Psychiatric Care	[ ] Rheumatic Fever	[ ] Hemophilia

Are you under the care of a physician? _____

_____

Is there anything else we should know about your medical history?

_____

Have you had any major surgeries in the last 3 years? [ ] Yes [ ] No

If yes, please explain: _____

Has bad breath ever been a concern? [ ] Yes [ ] No

Do you smoke? [ ] Yes [ ] No

Have you ever had an adverse reaction to any medication? [ ] Yes [ ] No
If yes, please explain: _____

Have you ever had an adverse reaction to any dental treatment? [ ] Yes [ ] No
If yes, please explain: _____

Are you allergic to latex? (doctors/hygienists gloves are latex) [ ] Yes [ ] No

Does your physician require you to take antibiotics for your dental visits? [ ] Yes [ ] No

When was your last dental cleaning? _____

Women:
Do you suspect that you are pregnant? [ ] Yes [ ] No Are you nursing? [ ] Yes [ ] No

Are you on birth control? [ ] Yes [ ] No

TURN OVER to complete the MEDICAL HISTORY UPDATE 

If you have a list of medications already, please check here: [ ]

Please list medications/doses you are currently taking:

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form:

Signature: _____Date: _____