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

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
[ ] Low Blood Pressure	[ ] Respiratory Disease	[ ] Blood Disease	immune disorders
[ ] 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

Please list medications/doses you are currently taking:

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

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

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:_____