JESSICA H. BRIGATI, DDS
FAMILY DENTISTRY

MEDICAL HISTORY UPDATE FORM

Name: _____ *(please print)*

Please list any prescription/over-the-counter drugs you are currently taking (use back of sheet if necessary:
Name of Medication _____ dosage _____ for _____
Name of Medication _____ dosage _____ for _____

Please list all current and past medical condition(s), surgeries, or serious illnesses (use back of sheet if necessary:
_____

Have you ever had any of the following diseases or medical problems?

Y N AIDS/HIV Positive (circle)
Y N Allergies/Hay Fever (circle)
Y N Anemia
Y N Arthritis
Y N Artificial Joints or Prosthetics (circle)
(describe)_____
Y N Asthma : Inhaler?_____
Y N Biopsy what_____ when_____
Y N Cancer/Chemotherapy/Radiation (circle)
Y N Diabetes
Y N Is your blood sugar monitored daily
Y N Emphysema
Y N Epilepsy/Seizures (circle)
(frequency)_____

Y N Glaucoma/ Cataracts (circle one)
Y N Heart Murmur/Mitral Valve Prolapse
Y N Heart Problems/Chest Pains
(describe)_____
Y N Hearing Problems (left or right ear)
Y N Herpes/Venereal Disease/ Other STD *(circle)*
Y N Hepatitis A, B, C (circle one)
Y N HPV (Human Papillomavirus)
Y N High/Low Blood Pressure (circle one)
Y N Implants (cosmetic or other)
what kind _____*when*_____
Y N Kidney or Urinary Problems
Y N Pacemaker: Date of Implantation: _____
Y N Rapid weight gain or loss greater than 10 lbs

Y N Scarlet Fever or Rheumatic Fever (Circle)
Y N Shortness of Breath or Swollen Ankles (circle)
Y N Sinus Problems
Y N Stomach or Digestive Problems
Y N Stroke when _____
Y N Surgery within the last five years_____
Y N Thyroid Trouble
Y N Tobacco Habit *what form: cigarettes chewing other*
are you currently practicing the above yes no (circle one)
how long have you been practicing the above: _____
*how often do you practice the above*_____
Y N Active or Remote Tuberculosis(TB) (circle one)
Y N Oral or Stomach Ulcer (circle)
Y N Blood Disorder _____

For Women: Y / N Are you pregnant? Y / N Nursing? Y / N Using Birth Control Medication?
Y / N Taking Hormone Medication Y / N Through Menopause Y / N Abnormal Pap Smear Date:_____

Do you have any drug allergies?_____

Home Dental Care: How often do you brush your teeth?_____ Do you use an electric toothbrush? _____
How often do you floss?_____

Address: _____ City/State: _____ Zip: _____
Email Address: _____@_____
Home Telephone #_____ Work #_____ext. _____
Fax #: _____Pager #: _____Cell #: _____

Insurance Co. Name:_____ Group#: _____
Customer Service 1.800 or 1.888 Number: _____ *(located on your insurance card)*
Who is the insured member in your family? □ Yourself □ Spouse □ Other
Insured's DOB _____ Insured's SS#___ ___ ___ - ___ ___ - ___ ___ ___ ___
Insured's Employer: _____ Wk#: _____

By physically or electronically signing below, I agree that the information provided today is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status. I understand that this office will assist me in getting my insurance reimbursement but I am financially responsible for all charges whether or not paid by insurance. Payment is due in full at time of treatment unless prior arrangements have been approved.

_____
Patient/Parent Signature

By physically or electronically signing below, I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges to the extent permitted under applicable law, I authorize release of any information relating to any dental claims.

_____
Patient/ Parent Signature

By physically or electronically signing below, I hereby authorize payment of dental benefits otherwise payable to me directly to Dr. Jessica H. Brigati, DDS.

_____ _____
Patient/Parent Signature ***Date***