JESSICA H. BRIGATI, DDS, PLLC
FAMILY DENTISTRY

MEDICAL HISTORY UPDATE FORM

If you are downloading and emailing this form, please save this file to your computer before filling it out.

Patient Name: _____ *(please print)*

Y☐ N☐ **Do you have any NEW drug allergies?**_____

Y☐ N☐ **Do you have any NEW medical condition(s), surgeries, or serious illnesses (use page 3 if necessary):**

_____

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

Y☐ N☐ AIDS	Y☐ N☐ Hepatitis A☐ B☐ C☐ (select one)
Y☐ N☐ HIV Positive	Y☐ N☐ HPV (Human Papillomavirus)
Y☐ N☐ Allergies/Hay Fever	Y☐ N☐ High☐/Low Blood Pressure☐ (select one)
Y☐ N☐ Anemia	Y☐ N☐ Implants (cosmetic or other)
Y☐ N☐ Arthritis	*what kind* _____*date*_____
Y☐ N☐ Artificial Joints or Prosthetics (circle)	Y☐ N☐ Kidney or Urinary Problems
(describe)_____	Y☐ N☐ Pacemaker: Date of Implantation: _____
_____	Y☐ N☐ Rapid weight gain or loss greater than 10 lbs
_____	Y☐ N☐ Scarlet Fever☐ or Rheumatic Fever☐ (Select One)
Y☐ N☐ Asthma : Inhaler?_____	Y☐ N☐ Shortness of Breath or Swollen Ankles (circle)
Y☐ N☐ Biopsy what_____ when_____	Y☐ N☐ Sinus Problems
Y☐ N☐ Cancer/Chemotherapy/Radiation	Y☐ N☐ Stomach or Digestive Problems
Y☐ N☐ Diabetes	Y☐ N☐ Stroke date _____
Y☐ N☐ Is your blood sugar monitored daily	Y☐ N☐ Surgery within the last five years
Y☐ N☐ Emphysema	what kind _____
Y☐ N☐ Epilepsy/Seizures	Y☐ N☐ Thyroid Trouble
frequency _____	Y☐ N☐ Tobacco Useage *what form:* ☐*cigarettes*
Y☐ N☐ Glaucoma/ Cataracts (circle one)	☐*chewing* ☐ vaping/ e-cigarettes ☐ *other* _____
Y☐ N☐ Heart Murmur/Mitral Valve Prolapse	*are you currently practicing the above* *yes*☐ *no*☐
Y☐ N☐ Heart Problems/Chest Pains describe	*how long have you been practicing the above:* _____
_____	*how often do you practice the above*_____
_____	Y☐ N☐ Active or Remote Tuberculosis (TB) (select one)
Y☐ N☐ Hearing Problems (left or right ear)	Y☐ N☐ Oral Ulcer☐ or Stomach Ulcer☐ (select one)
Y☐ N☐ Sexually Transmitted Disease (STD)	Y☐ N☐ Blood Disorder _____
Which One(s): _____	_____

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For Women:

Y☐ N☐ Are you pregnant? Y☐ N☐ Nursing? Y☐ N☐ Using Birth Control Medication?

Y☐ N☐ Hormone Medication Y☐ N☐ Through Menopause Y☐ N☐ Abnormal Pap Smear Date:_____

Home Dental Care:

How often do you brush your teeth? ☐2x/day ☐ 1x/day ☐ _____

Do you use an electric toothbrush? Y☐ N☐ How often do you floss? ☐2x/day ☐ 1x/day ☐ _____

Please list any NEW prescription/over-the-counter drugs you are currently taking (use back of sheet if necessary):

Medication Name _____ dosage _____ for _____

Medication Name _____ dosage _____ for _____

Medication Name _____ dosage _____ for _____

Medication Name _____ dosage _____ for _____

Medication Name _____ dosage _____ for _____

Do you have any updates to the following information?

Address: _____ City/State: _____ Zip: _____

Email Address: _____

Home Telephone #_____ Work #_____ext. _____

Fax #: _____Pager #: _____Cell #: _____

Do you have any updates to the following information?

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#: _____

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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.

_____ Sign / Date Here
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.

_____ Sign / Date Here
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, PLLC.

_____ _____ Sign / Date Here
Patient/Parent Signature ***Date***

Please use these lines below if you require any addition space for medications or medical history information

_____

_____

_____

_____

_____

_____

_____

Once you complete the form, save the file and then email it to our office at
lashann@brigatidds.com