



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



MEDICAL HISTORY UPDATE FORM

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#: _____



MEDICAL HISTORY UPDATE FORM

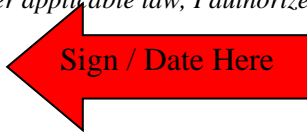
By physically or electronically signing below, I agree that the information provided today is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status. I understand that this office will assist me in getting my insurance reimbursement, 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, PLLC.

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