

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)

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

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: _____

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: _____

HIPAA Patient Information Update Form

Practice Information

Dentistry At South Brunswick
886 Georges Road, Monmouth Junction, NJ 08852
Phone: 732-951-0099 Fax : 732-951-2323

Patient Information

Patient Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Address Update (if applicable)

Street: _____

City: _____ State: _____ Zip: _____

Authorized Individuals

Please list anyone you authorize our office to discuss your dental treatment, appointments, or billing with:

Name	Relationship	Phone Number

I do **not** authorize anyone to receive my information

Communication Preferences

Appointment Reminders: Call Text Email

Billing/Insurance Questions: Call Text Email

Message Consent

- You may leave detailed messages
- You may leave appointment reminders only
- Do NOT leave messages

Privacy Acknowledgment

I acknowledge that I have received or been offered a copy of this office's Notice of Privacy Practices and understand my rights regarding my protected health information.

Signature: _____ Date: _____
