Branchburg Dental LLC
1069 Route 202 North
Branchburg, NJ 08876-3924

(908)722-8110
branchburgdental@verizon.net
www.branchburgdental.com

Medical & Dental History Form

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Are you currently taking any prescription or non-prescription medications?

☐ Do you use tobacco (smoking or chewing)?

If any of the previous questions are marked, please explain:

Please list and prescription medications or over the counter medications you are currently taking, including herbal or vitamin supplements:

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Please indicate if you have experienced any of the following:

- [ ] *PREMED-AMOX
- [ ] *PREMED-CLIND
- [ ] *PREMED-Other
- [ ] AIDS
- [ ] Allergies-Seasonal
- [ ] Allergy Amoxicillan
- [ ] Allergy Asprin
- [ ] Allergy Codeine
- [ ] Allergy Erythromycin
- [ ] Allergy Latex
- [ ] Allergy Penicillin
- [ ] Allergy Sulfa Drug
- [ ] Allergy Tetracycline
- [ ] Allergy-Epi
- [ ] Allergy-SEE CHART
- [ ] Allergy-Tylenol W/ C
- [ ] Alzhemier's
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Attention Def. Disor
- [ ] Blood Condition
- [ ] Blood Pressure-High
- [ ] Blood Pressure-Low
- [ ] Cancer
- [ ] Cancer-Chemo Therapy
- [ ] Cancer-RadiationTX
- [ ] Cholesterol
- [ ] Diabetes
- [ ] Dizziness
- [ ] Ear Condition
- [ ] Emphysema
- [ ] Epilepsy/Seizures
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Head Injuries
- [ ] Hearing Impaired
- [ ] Heart Condition
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] Kidney Condition
- [ ] Liver Condition
- [ ] MEDS-Biosphosphates
- [ ] MEDS-Blood thinners
- [ ] MEDS-Extensive List
- [ ] MEDS-Osteoporosis
- [ ] MEDS-see chart
- [ ] MVP
- [ ] Nervous Condition
- [ ] NO EPI
- [ ] OtherSEECLINICALNOTE
- [ ] Pacemaker
- [ ] PsychiatricCondition
- [ ] RespiratoryCondition
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Condition
- [ ] Stomach Condition
- [ ] Stroke
- [ ] Thyroid Condition
- [ ] Tuberculosis
- [ ] Venereal Disease
- [ ] Vertigo

- [ ] I DO NOT HAVE ANY OF THE ABOVE NOTED CONDITIONS

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Do you have any other health conditions that need further clarification? Is ther any other medical condition that we should be aware of? If so, please describe:

If you could change anything about your mouth, teeth, or smile, what would it be?

What is the reason for your dental visit today?

Prior Dentist's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Do you grind your teeth (either consciously or during sleep)?

Describe details:

WOMEN ONLY: Are you:

- ☐ Taking birth control medications?
- ☐ Pregnant?
- ☐ Taking medications for osteoporosis or have you EVER taken medications for such?

If pregnant, what is your anticipated due date? Please provide us with your OB/GYN physician and telephone number:

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To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient:

_____

PLEASE CLICK SUBMIT WHEN FINISHED

Response Date: _____