PATIENT HEALTH HISTORY

Patient Name _____ Birthdate _____
Your Physician's name _____ Physician's phone # _____
Are you having any pain or discomfort at this time: Yes_____ No _____

Please mark (x) to your response to indicate if you have or have had any of the following:

Cardiovascular
☐Artificial Heart Valve
☐Heart Conditions
☐High/low Blood Pressure
☐Pacemaker
☐Heart Surgery
☐Rheumatic Fever
☐Stroke
☐Heart Murmur
☐Heart Attack

Cancer, Type
☐Radiation to the head/neck

Viral Infections
☐HIV/AIDS
☐Venereal Disease
☐Cold Sores

Endocrinology
☐ Diabetes
☐Hepatitis
☐ Kidney Disease
☐ Liver Disease
☐ Thyroid Disease

Respiratory
☐ Asthma
☐ Lung Disease
☐ Shortness of Breath
☐ Emphysema
☐ Tuberculosis (TB)
☐Sinus Trouble

Women
☐ Pregnant
☐ Nursing

Hematologic/Lymphatic
☐ Anemia

Musculoskeletal
☐Arthritis
☐Artificial Joint
☐Pain in Jaw Joints/ TMJ

Neurological
☐ Anxiety/Depression
☐ Dizziness/Fainting
☐ Mental Health Treatment
☐Alcohol/Drug Addictions
☐Epilepsy/Seizure

Other
☐Glaucoma
☐ Bacteremia

Please list any disease or conditions not shown above_____
Please list any medications you are currently taking (Use back if necessary) _____
Please list any items or medicines to which you have reactions or allergies _____
Have you ever been hospitalized or had surgery? Explain _____
Are you required to take premedication prior to dental treatment? …… Yes No
Have you ever taken any drugs for osteoporosis or other bone disorder (i.e. Fosamax, Actonel)? …….. Yes No
Have you ever taken any IV forms of bisphosphonates (i.e. Aredia, Zometa)? …… Yes No
Are you currently taking any anticoagulants (blood thinners)? …… Yes No
Is this treatment a result of an injury, trauma, or accident? If yes, date? …… Yes No
Are you nervous or concerned about having dental work done? …… Yes No
Would you like Nitrous Oxide (Laughing gas)? …… Yes No
Do you smoke or use any tobacco products? …… Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the doctor at the next appointment without fail. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my endodontist, or any other member of her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. **I understand that treatment is no guarantee of success and that complications which may result in tooth loss or necessitate further treatment may occur. I also understand that I am to return to my dentist for permanent restoration of the treated tooth.** _____ ***INITIAL***

I request a handout of this office's Notice of Privacy Practice. **Yes**_____ Initial upon receipt_____ **No**_____
I request a handout describing additional treatment details. **Yes**_____ Initial upon receipt_____ **No**_____

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers (Ins.) and /or other health practitioners (dentists), and the following individuals (please list spouse, family members, or friends) _____. Further, I agree to hold Jenny Whatley, DDS, MSD and Whatley Endodontics harmless for the contents, additions omissions, or disclosures contained in my health records.

X_____ Date_____

WELCOME to our practice!
Thank you for selecting our dental healthcare team and for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us for assistance. We are always happy to help.