

Patient Name:

_____ Last

_____ First

_____ MI

_____ Preferred Name

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Alcohol Addiction | <input type="checkbox"/> Allergy - Acrylic |
| <input type="checkbox"/> Allergy - Anesthetic | <input type="checkbox"/> Allergy - Aspirin | <input type="checkbox"/> Allergy - Cephalexin | <input type="checkbox"/> Allergy - Epinephrin |
| <input type="checkbox"/> Allergy - Latex | <input type="checkbox"/> Allergy - Metal | <input type="checkbox"/> Allergy - Other | <input type="checkbox"/> Allergy - Penicillin |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Artific. Heart Valve | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Aspergers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Cold Sores/Fever Bl. | <input type="checkbox"/> Congenital Heart Dis |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Fosomax |
| <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> GERDS | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Heart Trouble/Dis |
| <input type="checkbox"/> Hemochromotosis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatits B or C |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Hives or Rash |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Mitral Valve Prolaps | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Naproxin |
| <input type="checkbox"/> Oral Contraceptives | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Parathyroid Disease |
| <input type="checkbox"/> Parkinsons | <input type="checkbox"/> Persistent Fever | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Sepsis | <input type="checkbox"/> Shingles | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Sjogren's Syndrome | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Stomach/Intestinal |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Surgery | <input type="checkbox"/> Swelling of Limbs | <input type="checkbox"/> Taking Birth Control |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Tubes in Ears | <input type="checkbox"/> Tumors or Growths | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Yellow Jaundice | | | |
- Recent Hospitalization Presently being treated for any other illness Pre-medication - explain below
- Pregnant/Planning Pregnancy Nursing

If any conditions or alerts selected above needs further clarification, please describe below

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Name of physician and date of last physical exam

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications (prescription and non-prescription), including regular dosages of aspirin. *

Please list any allergies and/or allergies to medications.

- * By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature. *

HIPAA Acknowledgment

I understand I can review and download/receive a copy of the Whitley Family Dental Notice of Privacy Practices found at www.billwhitleydds.com. I understand that I may inspect or copy any protected health information from my patient file. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my healthcare and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Please list the first and last names of any person(s) we may discuss your appointment, treatment, and or financial obligations with:

- * By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

Signature of patient, parent, or guardian completing this form:

Signature _____ 1:

Date

Relationship to patient:

- Patient Parent Guardian