Patient Health Information

First Name: _____ MI: ____ Last Name: _____

Please tell us who referred you to our practice _____

General dentist's name _____ Phone _____

Physician's name _____ Phone _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? Please select "Yes" or "No"

Y	N	AIDS/HIV	Y	N	Fainting/Dizziness	Y	N	Nervous Disorders
Y	N	Allergies	Y	N	Glaucoma	Y	N	Pacemaker
Y	N	Anemia	Y	N	Smoking	Y	N	Radiation Treatment
Y	N	Arthritis	Y	N	Hay Fever	Y	N	Radiation Therapy
Y	N	Artificial Joints	Y	N	Head Injuries	Y	N	Respiratory Problems
Y	N	Asthma/Emphysema	Y	N	Heart Disease/Angina	Y	N	Rheumatic Fever
Y	N	Blood Diseases	Y	N	Heart Murmur	Y	N	Rheumatism
Y	N	Bleeding/Hemophilia	Y	N	Heart Stent	Y	N	Sinus Problems
Y	N	Blood Thinners	Y	N	Heart Surgery/Stroke	Y	N	Steroid Treatment
Y	N	Cancer	Y	N	Hepatitis A, B or C	Y	N	Stomach Problems
Y	N	Chemotherapy	Y	N	High Blood Pressure	Y	N	Stroke
Y	N	Chronic Sinus	Y	N	Immunodeficiencies	Y	N	Thyroid Treatment
Y	N	Chronic Depression	Y	N	Jaundice	Y	N	TMJ Disorder
Y	N	Chronic Headaches	Y	N	Kidney Disease	Y	N	Tuberculosis
Y	N	Diabetes	Y	N	Liver Disease	Y	N	Tumors & Growth
Y	N	Epilepsy	Y	N	Mental Disorders	Y	N	Ulcers
Y	N	Excessive Bleeding	Y	N	Mitral Valve Prolapse	Y	N	Venereal Disease

WOMEN ONLY : Are you taking any birth control medication? Y N

NOTE: ANTIBIOTICS MAY INTERFERE WITH THE EFFECTIVENESS OF ORAL CONTRACEPTIVES.

Are you or could you be PREGNANT? Y N If Pregnant: Date due_____ Name of OB/GYN_____

Have you ever had any complications associated with previous dental treatment? Y N

If Yes, please explain_____

Are you currently taking any medications? Please list: _____

_____

Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel®, Fosamax® or Zometa, within the past twelve years? Y N

Have you ever taken Fen-Phen or any other diet drugs? Y N If Yes, please list_____

Are you currently under the care of a physician? Y N If Yes, please explain_____

Are you allergic to any medication (PENICILLIN, LATEX, ETC.)? Please list_____

List past surgeries_____

_____

Please list any other allergies that you may have: _____

I have read and understood each question, and have answered all of them truthfully and to the best of my knowledge and ability. I will not hold Greenville Endodontics or any other employee, including dentists and other staff, of Greenville Endodontics responsible for any errors and/or omissions that I may have made in the completion of this form as well as any consequences thereof. I understand that if any in change occurs in my health I am to report it to the dental office as soon as possible. I understand that upon completion of root canal therapy in this office, I MUST RETURN TO MY GENERAL DENTIST FOR PERMANENT RESTORATION.

_____ _____

Signature of patient (parent or guardian if Patient is a minor) Date