

Patient Health History

- ☐ Current Medical Treatment
- ☐ Surgery Past 2 Years
- ☐ High Blood Pressure
- ☐ Respiratory / Asthma
- ☐ Rheumatic Fever
- ☐ Hypertension / Circulation
- ☐ Immunocompromised
- ☐ Anemia / Bleeding
- ☐ Diabetes / Kidney
- ☐ Herpes
- ☐ Thyroid / Hormonal
- ☐ Hypoglycemia
- ☐ Smoke
- ☐ Shortness of Breath
- ☐ Cancer
- ☐ Radiation / Chemotherapy
- ☐ Tuberculosis
- ☐ Fatigue
- ☐ Swelling
- ☐ Hepatitis
- ☐ Pregnant

- ☐ Ulcers / Digestive
- ☐ Migraine / Headaches
- ☐ Epilepsy / Fainting
- ☐ Glaucoma / Visual
- ☐ Mental / Neurological
- ☐ Tumor / Neoplasm's
- ☐ Alcoholism / Addiction
- ☐ Infectious Diseases
- ☐ Sexually transmitted Disease
- ☐ Psychiatric Care
- ☐ TMJ
- ☐ Heart Disease
- ☐ Heart Murmur / Defect
- ☐ Pacemaker
- ☐ Heart Attack / Stroke
- ☐ Irregular Heart Beat
- ☐ Artificial Stent / Valve
- ☐ Any Transplant
- ☐ Joint Replacement
- ☐ Arthritis
- ☐ Other

Allergies

- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Clindamycin
- ☐ Antibiotic(s) _____
- ☐ Aspirin
- ☐ Tylenol
- ☐ Codeine
- ☐ Narcotics
- ☐ Local Anesthetic
- ☐ Latex
- ☐ Valium/Tranquilizer
- ☐ Nitrous Oxide
- ☐ Iodine
- ☐ OTHER _____

General Alerts

- ☐ Allergy
- ☐ Pre-Med Required
- ☐ Apprehensive
- ☐ Med Comp-Hep/HIV

Medications

- ☐ No Medications
- ☐ Antibiotic
- ☐ Pain Medicine
- ☐ Heart Medicine
- ☐ Aspirin
- ☐ Cortisone / Steroid
- ☐ Blood Thinner
- ☐ Blood Pressure
- ☐ Hormone
- ☐ Thyroid
- ☐ Birth Control Pills
- ☐ Insulin
- ☐ Ulcer / Nexium
- ☐ Bisphosphonates (Bone)
- ☐ Antidepressants
- ☐ Attached List of Medicines

IN EMERGENCY NOTIFY: _____ Phone: () _____

MY SIGNATURE ACKNOWLEDGES

1. I understand my responsibility and will comply with the office Financial Standards
2. I understand the Risks, Benefits & Alternatives and Consent to Endodontic Treatment
3. I understand and agree to the Release of Information and Assignment of Benefits
4. I have reviewed the Notice of Privacy Practices AND **have Declined** a copy
5. To the best of my knowledge, I have answered truthfully and completely

Please Initial all lines

I want a Copy _____

SIGNATURE: _____

(Patient or Responsible Party)

Print Name: _____

Date: _____