

MEDICAL-DENTAL HISTORY

Patient's Name _____ DOB _____ SSN _____

INSTRUCTIONS:

To receive treatment in this office you must answer all questions on this history form.

The questions asked relate directly to the safe and effective treatment you are to receive in the office - to the best of your ability honest answers must be given.

If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor.

Some of the questions may not relate to your medical condition; in that event you are to write "N/A" (not applicable) in the space provided. All questions must be answered.

To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission To Release Information." Please sign it in the presence of a member of the office staff.



ALL INFORMATION YOU SUPPLY ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR WRITTEN PERMISSION.

1. Name, address & telephone # of your physician _____

2. Date of last visit to your doctor _____ Purpose of visit _____

3. Do you suffer from any disability? _____ If yes, describe _____

4. Have you ever, or do you now take illegal drugs? _____ If yes, what drugs, and when taken?

Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.

5. Do you have AIDS, or are you HIV-positive? _____ If yes, describe and provide current status.

6. Do you now have, or have you ever had a venereal disease? _____ If yes, describe.

7. Have you ever had, or do you now have hepatitis? _____ If yes, describe. _____

8. For females: Are you pregnant? _____ If yes, when are you due? _____

9. For females: Are you taking birth control pills? _____ *Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.*

10. Are you taking any drugs or medications? _____ If yes, list and describe amounts and purpose.

Note: There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.

11. Have you ever had an allergic reaction to medication? _____ If yes, describe. _____

12. Have you lost weight recently? _____ If yes, describe. _____

Have You Ever Had Or Been Treated For:

13. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? _____

14. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? _____

15. Stomach or intestinal disease? _____

16. Abnormal blood pressure, excessive bleeding, or anemia? _____

17. Breathing problems, asthma, tuberculosis, or hay fever? _____

18. Cancer, X-ray treatments, or chemotherapy? _____

19. Diabetes? _____

20. Kidney problems or renal dialysis? _____

21. A stroke, convulsions, or fainting spells? _____

22. Tumors or growths? _____

23. Arthritis or rheumatism? _____

24. Have you ever had a major operation? If yes, describe. _____

25. Have you ever had a serious injury to your head or neck? If yes, describe. _____

26. Are you on a special diet? If yes, for what reason and describe. _____

27. Do you smoke? If yes, describe type and quantity. _____

28. Have you consulted or been treated by a psychiatrist, psychologist or counsellor? If yes, describe. _____

29. Are there any other problems about your health of which you are aware? _____

DENTAL HISTORY

Date of your last visit to a dentist _____

Reason for your last visit (or series of visits) _____

Do you have any of your X-rays or dental records? _____

In respect to any previous dental treatment have you:

30. Ever fainted? _____

31. Had an allergic reaction? _____

32. Had abnormal bleeding? _____

33. Any other complications during or following dental treatment? If yes, describe. _____

34. Do your gums bleed on brushing or eating? _____

35. Does food catch between your teeth? _____

NAME _____

WHAT DO YOU PREFER TO BE CALLED _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____

HOME PHONE _____ WORK _____

FAX _____ E-MAIL _____

WHOM MAY WE THANK FOR REFERRING YOU _____

NAME OF SPOUSE/PARENT/LEGAL GUARDIAN (CIRCLE ONE)

ADDRESS AND PHONE # IF DIFFERENT FROM PATIENT

PAYMENT IS REQUIRED AT THE TIME OF SERVICE. PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE. AN ITEMIZED FORM WILL BE FURNISHED TO THE PATIENT TO SUBMIT FOR REIMBURSEMENT.

SHOULD MY CHILD COME ALONE OR WITH ANOTHER DRIVER, I HEREBY GIVE DR. WAYNE L. WHITLEY PERMISSION TO DO ROUTINE EXAM, XRAYS AND FILLINGS.

I DO GIVE PERMISSION FOR MY CHILD TO HAVE ANELGESIA IF HE/SHE REQUESTS IT OR THE DOCTOR THINKS IT WOULD BE IN THE BEST INTEREST OF THE CHILD FOR COMFORT DURING TREATMENT.

I GIVE PERMISSION FOR DR. WHITLEY TO FURNISH INFORMATION TO MY INSURANCE COMPANY AND/OR OTHER DOCTORS CONCERNING TREATMENT.

I UNDERSTAND IF I FAIL TO MAKE APPOINTMENTS AS RECOMMENDED, DR. WHITLEY IS NOT RESPONSIBLE TO COMPLETE TREATMENT.

FOR PATIENTS UNDER THE AGE OF 18, PARENT OR GUARDIAN IS RESPONSIBLE FOR NOTIFYING DOCTOR IF CHANGE OCCURS IN STATUS OF PATIENTS LEGAL GUARDIANSHIP.

I GIVE PERMISSION FOR ROUTINE PHOTOGRAPHS FOR MY CHART.

SIGNATURE

DATE

WAYNE L. WHITLEY, D.D.S.
433 Bridgewater Street
Fredericksburg, VA 22401
(540) 371-9090
FAX (540) 371-9131

Notice of Privacy Practices Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. This Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information.

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
 - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights has been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
 - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
 - The right to receive confidential communications of protected health information.
 - The right to inspect and copy protected health information.
 - The right to amend protected health information.
 - The right to receive confidential communications of protected health information.
 - The right to inspect and copy protected health information.

- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (If signed by a personal representative of patient): _____

