FORREST R. JERKINS, D.D.S.

Today's Date _____

Medical History Form

Name _____ Home Phone _____

Local Address _____ Business Phone _____
Number, Street

Cell Phone _____

City _____ State _____ Zip Code _____

Other Address _____

_____ Email address: _____

Occupation (If retired, former occupation) _____ Date of Birth _____ / _____ / _____

Place of Employment _____

Social Security No. _____ Sex M F Height _____ Weight _____ Single _____ Married _____

Name of Spouse _____ Closest Relative _____ Phone _____

Reason for Today's Visit _____

Do you have Dental Insurance Yes No ***PLEASE GIVE CARD TO RECEPTIONIST***

PATIENTS WITH DENTAL INSURANCE

Name of Subscriber _____

Date of Birth of Subscriber _____ / _____ / _____

Social Security Number of Subscriber _____ - _____ - _____

Name of Employer _____

How did you find out about this office? _____

SPECIAL NOTE ABOUT X-RAYS TO OUR PATIENTS: X-Rays are a vital part of diagnosing your current dental health. We pledge to take as few x-rays as possible. New cleaning patients are required to have a panelipse x-ray every 5 years, and bite wings every 2 years. X-rays for emergency visits are determined by the extent of the disease. If you have any questions about having x-rays taken, please speak to the receptionist NOW. **We will NOT treat patients who refuse X-rays.**

Have you had Dental X-Rays in the past 2 years? _____ Yes_____ No Who has them? _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? ..... Yes No
2. Has there been any change in your general health within the past year? ..... Yes No
3. My last physical examination was in what year _____
4. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
5. The name of my physician is _____
6. Are you allergic to or have you had a reaction to:
   a. Local anesthetics (Novocaine) ..... Yes No
   b. Penicillin or other antibiotics ..... Yes No
   c. Aspirin ..... Yes No
   d. Codeine or other narcotics or pain medicines ..... Yes No
   e. Other _____
7. Do you have or have you had any of the following diseases or problems? _____
   a. Damaged heart valves or artificial heart valves, or previous heart infection ..... Yes No
   b. Cardiovascular Diseases: rheumatic heart disease, heart surgery in the past 6 months, mitral valve prolapse, pulmonary shunt, inborn heart defects, high blood pressure, recent heart attack. ..... Yes No
   c. Do you have any artificial joints, valves, or prosthetics devices? Any problems with them? _____ Yes No
   d. Hepatitis, jaundice or liver disease ..... Yes No
   e. AIDS or HIV infection ..... Yes No
   f. I know there is another side to this form ..... Yes No

- Over -