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: heart surgery in the past 6 months,
      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 -

g. Diabetes. When diagnosed. _____ What type? _____ Yes No

H. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No

Do you use an inhaler? _____

i. Persistent swollen glands in neck ..... Yes No

j. Current treatment for a sexually transmitted disease ..... Yes No

k. Current treatment for mental health problems ..... Yes No

l. Cancer When diagnosed?_____ How treated? _____ Yes No

m. Problems of the immune system ..... Yes No

8. Are you taking any medication(s) including non-prescription medicine? ..... Yes No

If so, what medicine(s) are you taking? _____

_____

_____

_____

_____

Please ask for additional sheet if needed

9. Have you had any abnormal bleeding or blood disorders? ..... Yes No

10. Have you ever had any treatment for a tumor or growth? ..... Yes No

11. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No

If so, explain _____

_____

12. Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain

_____

13. Are you wearing removable dental appliances? ..... Yes No

14. If so, when were they made? Upper _____ years ago Lower _____ years ago

15. Are they comfortable? ..... Yes No

Women

16. Are you pregnant? Yes _____ No _____ Nursing? Yes _____ No _____ Taking BCP's Yes _____ No _____

NOTE - Some medications commonly prescribed for dental problems may affect nursing and/or the use of birth control pills. Please ask the doctor or your pharmacist for more details.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

I understand that I am responsible for my bill and I will pay when the services are rendered. There is a Service Charge for all returned checks. Collections made by IC Systems, Inc.

CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, hereby authorize Dr. Forrest Jerkins (hereafter referred to as "Practice") to use and disclose the entire medical record concerning myself in accordance with the attached Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent.

By Patient: X _____

Please Sign Here

Date: _____

OR

By Patient's Representative: _____

_____

PRINT NAME, SIGN AND DESCRIBE AUTHORITY

Reviewed with Patient

Date _____

By _____

Reviewed with Patient

Date _____

By _____