Diane Jenkins D.M.D., M.S.
PERIODONTICS AND IMPLANTOLOGY
DISCOVER YOUR BEST ORAL HEALTH

Please complete this form and bring it with you to your appointment.

Today's Date _____ Patient Name _____

Preferred Name _____ Marital Status S M D W

Date of Birth _____ Social Security # _____ Height _____ Weight _____

Home Address _____

City _____ State _____ Zip Code _____

E-mail Address _____ Employer _____

Home # (_____)_____-_____Mobile # (_____)_____-_____ Work # (_____)_____-_____

Please note that by providing the above information, you agree that our office may utilize this information to contact you regarding any communication.

Dental Insurance Company * _____ Please present card for duplication.

Insured's Employer: _____

Insured's Name, SSN, DOB (if other than patient): _____

Name and Address of Responsible Party (if other than patient)

Name _____

Address _____

General Dentist's Name_____Referring Dentist's Name _____

Have you or any family member or friend been a patient of this office? Yes No

If so, who, and what is your relationship? _____

Emergency Contact & Relationship _____Phone_____

Please note that by listing a contact person above, you agree for our office to disclose any and all pertinent information regarding your care in the event of an emergency.

Please describe the reason for your visit:

_____

Medical History

Patient Name **Date of Birth**

General Physician _____ Phone _____ Date of Last Exam _____

1. Are you under the care of **another physician**? Yes No

If so, who and why? _____

2. Have you ever been **hospitalized** for any surgical operation, illness, or childbirth? Yes No

If yes, for what & when? _____

3. Are you taking any **medications** or vitamins/supplements? Yes No

If yes, what?_____

4. Please circle if you have taken any of the following medications for **Osteoporosis.**

If so, when? _____

Fosamax Boniva Actonel Bonefos Didronel Zometa Other: _____

5. Are you currently taking any blood thinners? (including Aspirin, Coumadin, Plavix) Yes No

If yes, what are you taking? _____

6. Have you ever been instructed to **pre-medicate with antibiotics** before your dental appointment due to a joint replacement or heart condition? Yes No

If yes, what type of joint replacement? _____

7. Are you allergic to, or had any adverse reactions to any drugs or medications (including anesthesia)?

If yes, what? _____

8. Are you allergic to latex or any rubber products? Yes No

9. Are you allergic to milk, eggs, or any other food products? Yes No

If yes, what? _____

10. Are you currently using any tobacco products? Yes No

11. Do you drink alcohol? Yes No

12. Do you use recreational drugs? Yes No

13. **WOMEN ONLY**
    a. Are you pregnant or think you may be pregnant? Yes No
    b. Are you nursing? Yes No
    c. Are you taking birth control pills, hormones, or female contraceptives? Yes No

Please turn over and continue on the following page.

Patient Name_____**Date of Birth**_____

Do you or have you had any of the following conditions?

Cardiovascular

High Blood Pressure …….. Yes No

Heart Disease …….. Yes No

Rheumatic Fever …….. Yes No

Heart Attack …….. Yes No

Heart Murmur …….. Yes No

Mitral Valve Prolapse …….. Yes No

Cardiac Pacemaker …….. Yes No

Heart Surgery/Stents …….. Yes No

Angina/Chest Pains …….. Yes No

Heart Infection/Endocarditis …….. Yes No

Respiratory

Asthma …….. Yes No

Shortness of Breath …….. Yes No

Emphysema …….. Yes No

Tuberculosis …….. Yes No

Chronic Obstructive Pulmonary Disease …….. Yes No

Neurologic

Fainting/Seizures …….. Yes No

Epilepsy/Convulsions …….. Yes No

Stroke …….. Yes No

Transient Ischemic Attacks (ISAs) …….. Yes No

Fibromyalgia …….. Yes No

Infectious Diseases/Immune Problems

Organ Transplant …….. Yes No

AIDs or HIV infection …….. Yes No

Hepatitis: Circle Type A B C Yes No

Infectious/Sexually Transmitted Disease …….. Yes No

MRSA …….. Yes No

Endocrine

Diabetes …….. Yes No

Thyroid/Parathyroid Problems …… Yes No

Liver Disease …….. Yes No

Jaundice …….. Yes No

Cancer/Blood Disorders

Cancer …….. Yes No

Type/Year: _____

Radiation or Chemotherapy …….. Yes No

Which area: _____

Anemia …….. Yes No

Stomach/Intestinal Problems

Irritable Bowel Syndrome…….. Yes No

Colitis, Diverticulitis…….. Yes No

Crohn's Disease…….. Yes No

Acid Reflux ……Yes No

Peptic Ulcer Disease …….. Yes No

Other

Swollen Ankles …….. Yes No

Kidney Disorders/Stones …….. Yes No

Arthritis …….. Yes No

Joint Replacement(s) ……Yes No

Frequently Tired …….. Yes No

Hay Fever/Allergies …….. Yes No

Glaucoma …….. Yes No

Adverse Reactions to Anesthesia ….. Yes No

Sleep Apnea ……Yes No

Other condition(s) not mentioned above:

_____

Please note that if you are a blood donor, check with your blood donation center regarding their guidelines for donation after receiving bone grafting. *

AUTHORIZATION AND RELEASE

I have read and understand the above information and, to the best of my knowledge, have answered all questions accurately and truthfully. I understand that incorrect information can be dangerous to my health and the health of others. I authorize Dr. Diane Jenkins to release any information including the diagnosis and records of any treatment to me or my dependent during the duration of such dental care and to any third party payer and/or health practitioners.

X_____

Signature of patient or parent if the patient is a minor