JOHN M. JACKSON, JR., D.M.D. P.C.

PATIENT REGISTRATION AND HEALTH HISTORY

PATIENT INFORMATION

Date _____ Is the patient Male ____ Female ____ Minor ____ Single ____ Married ____ (Check all that apply).

Patient's First Name _____ M.I. _____ Last Name _____

Patient's Address _____ Home Phone _____

City _____ State/Zip _____ Work Phone _____

Cell # _____ Email Address _____

Birth Date _____ Age _____ SS# _____

Employer or School (if student) _____ Occupation _____

In case of emergency notify _____ Phone #_____

Relationship to Patient _____ Referred By _____

RESPONSIBLE PARTY (OTHER THAN SELF)

Name _____ SS# _____ Date of Birth _____

Address _____ (If different from above)

Home # _____ Work # _____ Ext. _____

Cell # _____ Relationship to Patient _____

Employer _____ Address _____

E-mail Address _____

DENTAL INSURANCE INFORMATION

TO INSURE THAT YOUR INSURANCE IS FILED CORRECTLY, YOU ARE RESPONSIBLE FOR BRINGING INSURANCE FORMS FOR EACH VISIT. PAYMENT FOR YOUR ESTIMATED PORTION OF CHARGES INCLUDING ANY DEDUCTABLES ARE DUE THE DAY OF SERVICE.

Policy Holder _____ Relationship to Patient _____

Policy Holder's SS# _____ Birth Date _____

Employer _____ Group # _____

Employer Address _____ Phone # _____

Insurance Company _____ Member I.D. #_____

Insurance Company's Address _____

SECONDARY DENTAL INSURANCE

Policy Holder _____ Relationship to Patient _____

Policy Holder's SS# _____ Birth Date _____

Employer _____ Group # _____

Employer Address _____ Phone # _____

Insurance Company _____ Member I.D. #_____

Insurance Company's Address _____

PLEASE COMPLETE HEALTH HISTORY INFORMATION ON BACK

Do you have or have you had any of the following problems or diseases?

I. CARDIOVASCULAR SYSTEM
- ☐ ☐ A. High Blood Pressure
- ☐ ☐ B. Stroke
- ☐ ☐ C. Rheumatic Fever/Heart Disease
- ☐ ☐ D. Heart Attack/MI
- ☐ ☐ E. Chest Pain/Angina
- ☐ ☐ F. Heart Defects or Murmurs
- ☐ ☐ G. Heart Surgery
  - ☐ ☐ 1. Pacemaker
  - ☐ ☐ 2. Prosthetic Valve
  - ☐ ☐ 3. By-Pass/Stents
  - ☐ ☐ 4. Other
- ☐ ☐ H. Other

II. RESPIRATORY SYSTEM
- ☐ ☐ A. Asthma
- ☐ ☐ B. Emphysema
- ☐ ☐ C. Tuberculosis (TB)
- ☐ ☐ D. Shortness of Breath
- ☐ ☐ E. Persistent Cough
- ☐ ☐ F. Use of Tobacco
- ☐ ☐ G. Other

III. ENDOCRINE SYSTEM
- ☐ ☐ A. Diabetes
- ☐ ☐ B. Thyroid Disease
- ☐ ☐ C. Adrenal Gland Disorder
- ☐ ☐ D. Other

IV. HEMATOPOIETIC SYSTEM
- ☐ ☐ A. Anemia
- ☐ ☐ B. Bleeding Disorder
- ☐ ☐ C. Leukemia
- ☐ ☐ D. AIDS
- ☐ ☐ E. HIV
- ☐ ☐ F. Other

V. GENITOURINARY SYSTEM
- ☐ ☐ A. Kidney Infections
- ☐ ☐ B. Bladder Infections
- ☐ ☐ C. Genital Herpes
- ☐ ☐ D. Venereal Disease
- ☐ ☐ E. Other

VI. NEUROLOGICAL SYSTEM
- ☐ ☐ A. Seizures
- ☐ ☐ B. Epilepsy
- ☐ ☐ C. Fainting Spells
- ☐ ☐ D. Convulsions
- ☐ ☐ E. Paralysis
- ☐ ☐ F. Psychiatric Treatment
- ☐ ☐ G. Other

VII. GASTROINTESTINAL/LIVER
- ☐ ☐ A. Ulcers
- ☐ ☐ B. Bleeding
- ☐ ☐ C. Hepatitis
- ☐ ☐ D. Jaundice
- ☐ ☐ E. Cirrhosis
- ☐ ☐ F. Other

VIII. MUSCULOSKELETAL SYSTEM
- ☐ ☐ A. Prosthetic Joint (Knee/Hip)
- ☐ ☐ B. Osteoporosis
- ☐ ☐ C. Degenerative Muscular Disease
- ☐ ☐ D. Other

Are you taking any of the following medications?

PLEASE LIST YOUR SPECIFIC MEDICATIONS:

- ☐ ☐ A. Anticoagulants (Blood Thinners)
- ☐ ☐ B. Aspirin/Tylenol
- ☐ ☐ C. Antibiotics or Sulfa Drugs
- ☐ ☐ D. Corticosteroids
- ☐ ☐ E. Tranquilizers
- ☐ ☐ F. Medications for Heart Condition
- ☐ ☐ G. Medications for Allergies
- ☐ ☐ H. Medicine for High Blood Pressure
- ☐ ☐ I. Insulin, Tolbutamide (Orinase)
- ☐ ☐ J. Thyroid Medication
- ☐ ☐ K. Digitalis
- ☐ ☐ L. Nitroglycerin
- ☐ ☐ M. Bisphosphonate (Fosamax, Boniva)
- ☐ ☐ N. Other

Are you Allergic to or Have you Reacted Adversely to:

- ☐ ☐ A. Penicillin
- ☐ ☐ B. Tetracycline
- ☐ ☐ C. Any other Antibiotics (Emycin, Keflex or Sulfa)
- ☐ ☐ D. Local Anesthetics (Novacaine, Lidocaine, Carbocaine, Marcaine)
- ☐ ☐ E. Barbiturates, Sedatives or Sleeping Pills
- ☐ ☐ F. Aspirin
- ☐ ☐ G. Acetamenaphen (Tylenol)
- ☐ ☐ H. Ibuprofen (Motrin, Advil, Nuprin)
- ☐ ☐ I. Codeine
- ☐ ☐ J. Ultram/Tramadol
- ☐ ☐ K. Demerol
- ☐ ☐ L. Other Medications
- ☐ ☐ M. Foods, Dust, Pollens, etc.
- ☐ ☐ N. Latex
- ☐ ☐ O. Other

- ☐ ☐ 1. Are you presently under the care of a physician? Why? _____
- ☐ ☐ 2. Have you ever been told that you have a tumor or malignancy? What? _____ Where? _____ When? _____ Treatment: _____
- ☐ ☐ 3. Have you ever had any serious trouble with previous dental treatment? Describe: _____
- ☐ ☐ 4. In general, do dental treatments make you tense or cause you to worry?
- ☐ ☐ 5. Are you dissatisfied with the appearance of your teeth? Why? _____
- ☐ ☐ 6. Do your gums bleed easily when you brush? Where? _____
- ☐ ☐ 7. Do you have a tooth or teeth that frequently feel loose? Where? _____
- ☐ ☐ 8. Have you ever suffered a severe blow to your face, chin or jaw? When? _____
- ☐ ☐ 9. Do you notice popping, clicking or soreness in your jaw joints (in front of your ears)?
- ☐ ☐ 10. Do you find it difficult to sometimes open wide?
- ☐ ☐ 11. Are you aware you are clenching or grinding your teeth? When? _____
- ☐ ☐ 12. Is there anything we should know about your general health or dental condition before we proceed? If so describe in your own words.

I authorize release of any medical records deemed necessary which may aid in my dental treatment. In furtherance of the profession of Dentistry and the dental health of the public, I do hereby consent to photographs being taken of my oral and facial structures, and subsequent publication solely for educational and scientific purposes.

Signature _____ Date _____

DOCTOR'S COMMENTS: _____