Keven P. Jackson, DDS, P.C. 225-16 Linden Blvd., Cambria Heights, N.Y. 11411 718-978-0226

Name:____
Address:____
Phone:#____________________(h) _____________________(o) ___________________________(c)
DOB:_________________ Height_____________ Weight___________________
Occupation _____________________________________ SS#__________________________
Single__ Married____ Name of Spouse:_________________________
E-mail Address:__________________________ Emerg. Name & Phone#_______________________

If you are completing this form for another person, what is your relationship to that person?
____

Referred by:____________________

Please circle yes or no for the following questions, 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 condition in the past year? Yes No
3. My last physical examination was on:_____________
4. Are you now under the care of a physician?________________________ Yes No
   If so, what is the condition being treated?__________________________________
5. The name & address of my Physician is

____

6. Have you had any serious illness or operation?__________________ Yes No
   If so, what was the illness or operation?_______________________________________
7. Have you been hospitalized or had a serious illness in the past 5 years? Yes No
   If so, what was the problem?____
8. Do you have or have you had any of following diseases or problems:
   a. Damaged heart valves, artificial heart valves, incl. heart murmur Yes No
   b. Congenital Heart lesion, mitral valve prolapsed? Yes No
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusions, high Pressure, arteriosclerosis, stroke) ____________________________ Yes No
      1. Do you have pain in chest upon exertion? (Angina?) Yes No
      2. Are you ever short of breath after mild exercise? Yes No
      3. Do your ankles swell? Yes No
      4. Do you have a pacemaker?____________________________ Yes No
      5. Do you have Rheumatic Fever or Heart Disease? Yes No

9. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? Y N
   a. Do you bruise easily? ____ Yes No
   b. Have you ever required a blood transfusion?_____________________ Yes No
      If so, explain the circumstances:____
      ____

10. Do you have any blood disorders, such as anemia? _________________ Yes No

11. Have you had surgery, x-ray or drug treatment for a tumor, growth or other condition on your head or neck?____ Yes No
12. Are you taking any drug or medicine? ____________________________ Yes No
    If so, what?____
13. Are you taking any of the following?
    a. Antibiotics or sulfa drugs____________________________________ Yes No
    b. Anticoagulants (blood thinners)______________________________ Yes No
    c. Medicine for high blood pressure______________________________ Yes No
    d. Cortisone (steroids)____ Yes No
    e. Tranquilizers____ Yes No
    f. Antihistamines____ Yes No
    g. Aspirin____ Yes No
    h. Insulin, tolbutamide (Orinase) or similar drug____________________ Yes No
    i. Digitalis or drugs for heart trouble_____________________________ Yes No
    j. Nitroglycerin____ Yes No
    k. Other____
14. Are you allergic or have you reacted adversely to:
    Local anesthetics____ Yes No
    Penicillin or other antibiotics______________________________________ Yes No
    Sulfa Drugs____ Yes No
    Barbiturates, sedatives or sleeping pills______________________________ Yes No
    Aspirin____ _ Yes No
    Iodine____ Yes No
    Codeine or other narcotics______________________________________ Yes No
    Metals____ Yes No
    Latex (rubber)____ Yes No
    Iodine ____ Yes No
    Animals ____ Yes No
    Food ____ Yes No

    Other____
15. Do you have any disease, condition or problem not listed above that you think I should know about?
    Yes No
    If so, Explain____
    a. Do you get short of breath when you lie down or do you require extra pillows when you sleep? Yes No
    b. Allergy____ Yes No
    c. Sinus trouble -____ Yes No
    d. Asthma or hay fever _______________________________________ Yes No
    e. Hives or skin rash ____ Yes No

f. Fainting spells or seizures __________________________________ Yes No

g. Diabetes ____ Yes No

Do you have to urinate (pass water) more than 6 times per day? Yes No

Are you thirsty much of the time? _______________________________ Yes No

Does your mouth frequently become dry?_________________________ Yes No

h. Hepatitis, jaundice or liver disease?________________________________ Yes No

i. Arthritis____ Yes No

j. Inflammatory rheumatism (painful swollen joints)___________________ Yes No

k. Stomach Ulcers____ Yes No

l. Kidney trouble____ Yes No

m. Tuberculosis/ or have been exposed to anyone w/TB_________________ Yes No

n. Do you have a persistent cough or cough up blood?_________________ Yes No

o. Low blood pressure____ Yes No

p. Venereal disease____ Yes No

q. Epilepsy____ Yes No

r. Psychiatric problems____ Yes No

s. Cancer____ Yes No

t. AIDS or other immunosuppressive disorder___________________________ Yes No

u. Have you or do you have Thyroid Problems?_________________________ Yes No

v. Do you have osteoporosis?____ Yes No

DENTAL

16. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? Yes No
17. Have you had anything to eat or drink in the last 4 hours? _______________ Yes No
18. Are you wearing removable dental appliances? -_________________________ Yes No
19. Have you had any periodontal (gum) treatments? _______________________ Yes No
20. Have you ever had orthodontic (braces) treatment? _____________________ Yes No
21. Have you had any problems associated w/previous dental treatment?______ Yes No
22. Do you have earaches or neck pains?___________________________________ Yes No
23. Do you have any clicking , popping or discomfort in the jaw?________________ Yes No
24. Do you brux or grind your teeth?____ Yes No
25. Do you have sores or ulcers in mouth?___________________________________ Yes No
26. Do you participate in active recreational activities?_______________________ Yes No
27. Have you ever had a serious injury to your head or mouth? ________________ Yes No
28. Do you Snore? ____ Yes No

WOMEN

29. Are your pregnant? ____ Yes No
30. Do you have any problems associated with your menstrual period? Yes No
31. Are you nursing? ____ Yes No
32. Oral contraceptive or other hormonal therapy ___________________ Yes No

What is your chief Dental Complaint/ Reason for visit?__________________________________
____

How do you feel about your Smile?____
____

A FEE OF $35.00 WILL BE CHARGED FOR
BROKEN APPOINTMENTS UNLESS 24 HOUR
NOTICE IS GIVEN. ________________________(Patient signature)

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

________________________________ ___________________

Signature Date