LARRY S. JACOBSON, D.D.S., P.C.

Suite 690, Rockhill Medical Plaza West
6675 Holmes
Kansas City, Missouri 64131

PRACTICE LIMITED TO PERIODONTICS

(816) 444-7787

NAME _____ DATE OF BIRTH _____ S.S. # _____

ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP CODE _____

EMPLOYER _____ OCCUPATION _____ BUS. PHONE _____

SPOUSE'S NAME _____ EMPLOYER _____ BUS. PHONE _____

PERSON RESPONSIBLE FOR ACCOUNT _____

DENTAL INSURANCE COMPANY _____ REFERRED BY _____

PRESENT DENTIST _____ LAST VISIT _____

PHYSICIAN _____ LAST VISIT _____

MEDICAL HISTORY

Are you under a physician's care now? ..... Yes ☐ No ☐
Are you taking any medicine now? ..... Yes ☐ No ☐
Do you smoke? What _____ How much? _____ ..... Yes ☐ No ☐
Do you bleed for a long time when you cut yourself? ..... Yes ☐ No ☐
Have you experienced an unusual reaction to penicillin or other drugs? ..... Yes ☐ No ☐
Has there been any change in your general health in the past year? ..... Yes ☐ No ☐
Have you ever experienced an unusual reaction to a dental anesthetic? ..... Yes ☐ No ☐
Has your appetite changed lately? ..... Yes ☐ No ☐
Are you thirsty much of the time? ..... Yes ☐ No ☐
Is there additional information about your general health that we should know? ..... Yes ☐ No ☐
Have you taken steroids? ..... Yes ☐ No ☐
Have you tested HIV positive? ..... Yes ☐ No ☐

Have you ever had any of the following: (check)

☐ Heart Attack	☐ Swollen Ankles	☐ Veneral Disease	☐ Stomach Problem	☐ Hepatitis
☐ Heart Pacemaker	☐ Heart Valve Prothesis	☐ Emphysema	☐ Arthritis	☐ Liver Disease
☐ Chest Pains	☐ Stroke	☐ Tuberculosis	☐ Glaucoma	☐ Kidney Disease
☐ High Blood Pressure	☐ Fainting	☐ Night Sweats	☐ Contact Lenses	☐ Asthma
☐ Rheumatic Disease	☐ Anemia	☐ Cancer	☐ Lens Implant	☐ Herpes
☐ Heart Murmur	☐ Thyroid Problem	☐ Radiation	☐ Frequent Infections	☐ Aids Exposure
☐ Joint Replacement	☐ Hay Fever	☐ Epilepsy	☐ Diabetes	☐ Weight Loss

WOMEN:

Are you taking oral contraceptives? ..... Yes ☐ No ☐
Are you taking hormones? ..... Yes ☐ No ☐
Have you had a hysterectomy? ..... Yes ☐ No ☐
Are you pregnant? ..... Yes ☐ No ☐
Are your menstrual periods irregular? ..... Yes ☐ No ☐
Have you passed menopause? ..... Yes ☐ No ☐

ORAL HISTORY

Do you have a condition in your mouth causing you pain or discomfort? ..... Yes ☐ No ☐
Do you have bleeding gums? ..... Yes ☐ No ☐
Do you have a bad taste in your mouth? ..... Yes ☐ No ☐
Do you have frequent canker sores or cold sores? ..... Yes ☐ No ☐
Have you ever had a severely sore mouth? ..... Yes ☐ No ☐
Do you have any sensitive teeth? ..... Yes ☐ No ☐
Does your jaw click when you chew? ..... Yes ☐ No ☐
Do you grind or clench your teeth during the day or night? ..... Yes ☐ No ☐
Have you ever had extensive periodontal treatment? ..... Yes ☐ No ☐
Have your teeth been cleaned within the past year? ..... Yes ☐ No ☐
Has a dentist ever ground your teeth to correct your bite? ..... Yes ☐ No ☐
What is your chief complaint about your mouth or teeth? _____

_____

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED

Signature _____ Date _____

Patient is liable for any amount not covered by insurance.