David L. Jolkovsky, DMD, MS
Diplomate, American Board of Periodontology

1205 Drake Drive, #B, Davis, CA 95616
(530) 758-1530 FAX (530) 758-1236

The following information is confidential and for our records only!
Please fill out as completely as possible

PATIENT INFORMATION

Name____Date______________

Address_____________________________________How Long?__________
City State Zip

Home Phone ________Work Phone________ e-mail ________________SS#__________

Date of Birth______________ Age______ Sex______Weight_____Marital Status__________

Employer____________________________Occupation______________________

Spouse / Parent____________________Date of Birth__________SS#__________

Employer____________________________Occupation______________________

Insurance Company______________ Emergency Contact______________ Phone#________

Your General Dentist is Dr.__________________How long have you been a patient?________

Your Physician is Dr.______________________Phone #_____________________

Why were you referred to us?____

MEDICAL HISTORY

What is your estimation of your general health? GOOD FAIR POOR

YES NO Are you currently under the care of a physician. If yes, for what?

____
____
____
____
____

YES NO Are you currently taking any pills, medications or drugs? If yes, please list. (including aspirin):

____
____
____
____

YES NO Have you ever had any major operations, illnesses, or been hospitalized? If yes, for what.

____
____

YES NO Have you ever been told you need to be pre-medicated prior to dental treatment? If yes, with what?

____

YES, NO Have you had any unusual reactions or allergies to any pill, drug, medication, or food? If yes, please list.

____
____
____
____
____
____

ALLERGIES

Please check if you have had any kind of reaction to any of the following...

______Penicillin
______Tetracycline
______Erythromycin
______Sulfa Drugs
______Aspirin
______Codeine
______Vicodin
______Darvocet
______Valium
______Halcion
______Local Anesthetic(novacaine)
______Nitrous Oxide(laughing gas)

CONTINUED ON BACK

MEDICAL HISTORY CONTINUED

YES NO Have you ever smoked? When?_________ How long?_________ How much?________
YES NO Have you ever chewed tobacco?
YES NO Do you drink alcohol?
YES NO Are you on a diet of any kind?
YES NO Have you recently gained or lost excessive amounts of weight?
YES NO Has any member of your family had tuberculosis, diabetes, heart disease, Allergies, bleeding problems or cancer? If yes, who and what?____________________
____
YES NO Have you ever been treated for a nervous or mental disorder?
YES NO Have you ever had abnormal bleeding after a cut or tooth extraction?
YES NO Is there anything you are anxious or nervous about concerning dental treatment? Explain____
YES NO Have you ever taken Fosamax (alendronate), Actonel (risedronate), Boniva (ibandronate) or any other Bisphosphonate ?

YES	NO	Rheumatic Fever	YES	NO	Cortisone shots or steroids
YES	NO	Heart Disease	YES	NO	Ulcers (stomach or Duodenal)
YES	NO	Heart Murmur	YES	NO	Kidney or bladder trouble
YES	NO	Heart Attack DATE ____________	YES	NO	High or low blood pressure
YES	NO	Arteriosclerosis	YES	NO	Thyroid or parathyroid disease
YES	NO	Diabetes	YES	NO	Asthma or difficulty breathing
YES	NO	Stroke	YES	NO	Anemia or other blood disorders
YES	NO	Tumors or growths	YES	NO	Arthritis or Rheumatism
YES	NO	Radiation therapy	YES	NO	Painful or swollen joints
YES	NO	Healing problems	YES	NO	Dizziness or light headed
YES	NO	Frequent vomiting or diarrhea	YES	NO	Rashes or skin disorders
YES	NO	Frequent headaches	YES	NO	Epilepsy, convulsions,fainting spells
YES	NO	Hepatitis, jaundice, liver disease	YES	NO	Shortness of breath or chest pains
YES	NO	Allergies or sinus trouble	YES	NO	Sexually related diseases
YES	NO	Swelling of hands, feet or eyes	YES	NO	Glaucoma
YES	NO	Cancer______________________	YES	NO	Auto Immune Disease

YES NO Are there any other dental or medical issues that we should know about?
____

WOMEN ONLY

YES NO Are you pregnant? If yes, what month?______________________________
YES NO Are you taking birth control pills?
YES NO Have you reached menopause (change of life)?

PATIENT ACKNOWLEDGEMENT

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, Dr. Jolkovsky has my permission to ask the respective health care provider or agency, who may release such information to Dr. Jolkovsky. I will notify the doctor of any changes in my health or medications.

Patient/Guardian signature____ Date______________

DR.'S NOTES

Dr.'s signature____ Date______________

DENTAL HEALTH INFORMATION

YES NO Do you consider yourself in good dental health?

YES NO Do you think that your teeth are affecting your health in any way?

YES NO Are you dissatisfied with the appearance of your teeth?

YES NO Are you dissatisfied with your chewing ability?

YES NO Have you noticed any loosening of your teeth?

YES NO Does food tend to become caught between your teeth?

YES NO Do you suffer from pain and/or swelling of your gums?

YES NO Do your gums often bleed when you brush your teeth?

YES NO Do you have an unpleasant odor or taste in your mouth?

YES NO Are you missing any teeth? Reasons:_____decay ______gum disease ______other

YES NO Have the missing teeth been replaced?

YES NO Do you ever have any soreness, pain, clicking or popping in the area in front of your ears?

YES NO Do you feel apprehensive when you are having dental treatment?

YES NO Would you like to use nitrous oxide (laughing gas)?

YES NO Does the fear of pain make you postpone your dental treatment?

YES NO Is it important for you to keep your teeth?

YES NO Would you spend fifteen minutes a day in order to keep your natural teeth?

Have you ever had any of the following? (Check that applies to you)

- ❑ Orthodontic treatment (braces)
- ❑ Oral surgery (extractions, etc.)
- ❑ Periodontal treatment
- ❑ Your teeth ground down or your bite adjusted
- ❑ A nightguard or other appliance

Do you?

- ❑ Clench or grind your teeth while awake or sleeping?
- ❑ Bite your lips or cheeks regularly?
- ❑ Hold foreign objects in your teeth?
- ❑ Breathe primarily through your mouth?

When did you last have your teeth cleaned prior to this appointment?________________________

How long before that?____

How often do you see your dentist?________________________________

How often do you brush your teeth?________________________________

Do you use a: ______ Hand toothbrush ______Electric toothbrush What brand? ________________

Is your toothbrush: ______soft ______medium ______hard

What else do you use to clean your teeth? (floss, toothpick, waterpik, etc)____________________

How often?____

If we find something that needs attention that your insurance will not cover, what would you like us to do?

____

David L. Jolkovsky, DMD, MS
Diplomate, American Board of Periodontology

1205 Drake Dr., #B, Davis, CA 95616
(530) 758-1530 FAX (530) 758-1236

DENTAL INSURANCE INFORMATION

Please fill out as completely as possible!!

PATIENT NAME:______________________ Date of birth__________

PRIMARY CARRIER	SECONDARY CARRIER
Insured Person's Employer ______________________	Insured Person's Employer ______________________
Insured Person's Name ______________________	Insured Person's Name ______________________
Insured Person's Social Security # ______________________	Insured Person's Social Security # ______________________
Insured Person's Date of Birth ______________________	Insured Person's Date of Birth ______________________
Relationship to Patient ______________________	Relationship to Patient ______________________
Insurance Company Name ______________________	Insurance Company Name ______________________
Insurance Company Address ______________________ ______________________	Insurance Company Address ______________________ ______________________
Insurance Company Phone # ______________________	Insurance Company Phone # ______________________