Wilson Family Dentistry
Amy Wilson DMD, LLC
8318 Stouts Road
Morris AL 35116
(205)647-4705
dr.amywilson@gmail.com

Patient Information

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Spouse, Parent or Guardian name, relationship and phone numbers:

_____

Emergency contact and phone number:

_____

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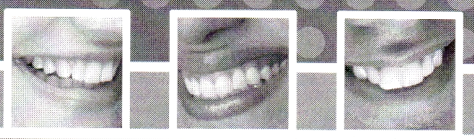

Whom may we thank for referring you to our practice?

Medical History

Please list your physician and his/her phone number:

Date of your last physical:

Have you have any surgeries or hospitalizations within the last 5 years? If so, please list.

Please list ANY and ALL medications you are currently taking.

Do you take or have you ever taken any medications for osteoporosis (bisphosphonates drugs), such as Zometa, Aredia, Boniva, Reclast, or Fosamax?

◯ Yes ◯ No

Do you take any steroid medications, including Cortisone or Prednisone?

◯ Yes ◯ No

Have you ever undergone treatment for alcohol or drug abuse?

◯ Yes ◯ No

Do you smoke or use any form of tobacco? If so, how much?

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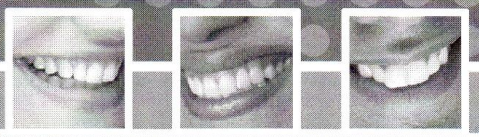

For females, are you currently pregnant, or think you may be pregnant? If yes, when is your due date?

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

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ Allergy - Aspirin
☐ Allergy - Codeine	☐ Allergy - Latex	☐ Allergy - Other	☐ Allergy - Penicillin
☐ Allergy - Sulfa	☐ Allergy-Anesthetics	☐ Anemia	☐ Angina/Chest Pain
☐ Artificial Joints	☐ Asthma	☐ Blood Disease	☐ Blood Thinners
☐ Breastfeeding Now	☐ Cancer	☐ Cardiac Pacemaker	☐ Chemotherapy
☐ Diabetes	☐ Epilepsy/Siezures	☐ Excessive Bleeding	☐ Fainting/Dizziness
☐ Glaucoma	☐ Gum Treatment	☐ Head Injuries	☐ Heart Attack
☐ Heart Disease	☐ Heart Murmur	☐ Heart Valve Replaced	☐ Hepatitis
☐ High Blood Pressure	☐ HIV/AIDS	☐ Jaundice	☐ Kidney Disease
☐ Liver Disease	☐ Mental Disorders	☐ Mouth Ulcers	☐ Radiation Treatment
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism/Arthritis	☐ Sinus/Hay Fever
☐ Stomach Problems	☐ Stroke	☐ TMJ Problems	☐ Tuberculosis
☐ Tumors/Growths	☐ Venereal Disease		

Do you have any other or additional diseases? If so, please list.

Please list any additional drug or other allergies not listed above.

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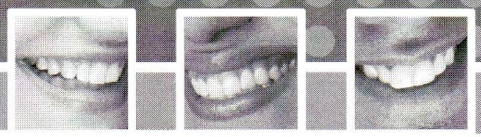

Consent for Services

☐ By checking this box, I understand that payment is my obligation regardless of insurance or any third party involvement. I agree to be the responsible party for payment for any treatment rendered. I certify that I have read and understand the information in this questionnaire. To the best of my knowledge, the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I have been given copies of this office's HIPPA compliance policy. I give consent to Dr. Wilson and her staff for treatment of my dental needs.

In the event Wilson Family Dentistry is required to take action to collect any unpaid balances or amounts due by patient, patient hereby agrees to reimburse Wilson Family Dentistry, and Wilson Family Dentistry shall be entitled to recover, the cost of any and all expenses related to said collection, including but not limited to filing fees, court costs and a reasonable attorney's fee.

Signature

Relationship to patient:

Response Date: