Wilson Family Dentistry

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Patient Information

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

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

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

The following is for: ○ the patient ○ the person responsible for payment ○ both ○ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

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

_____

_____

Emergency contact and phone number:

_____

_____

Whom may we thank for referring you to our practice?

_____

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Medical History

Please list your physician and his/her phone number:

_____

_____

Date of your last physical:

_____

_____

Have you had 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?

_____

_____

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

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

_____

_____

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

_____

_____

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 HIPAA 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.

Our desire is to make appointments as comfortable and convenient as possible. If it becomes necessary to cancel or change an appointment, we request to be notified a minimum of 48 hours prior to the time of appointment. Patient's breaking or cancelling an appointment without 48 hours notice will be charged as follows: $40 for hygiene appointments and $75 for doctor appointments. We feel that our patient's time is valuable and schedule individual time with each patient to allow the quality and personal care every patient deserves.

Signature

_____

_____

Relationship to patient: _____

Response Date:
____/____/_____