JOHN C. WILSON, D.D.S.

Cutting Edge Technology

Old-Fashioned Commitment

GENERAL DENTISTRY

Welcome

Please fill out this form completely, it is important for your care.

About You

Today's Date: _____ ☐ **Married** ☐ **Single** ☐ **Partnered** ☐ **Divorced** ☐ **Separated** ☐ **Widowed** **Preferred Name:** _____

Legal Name: _____ ☐ **M** ☐ **F** **Birthdate:** ____/____/____ **Age:** _____ **SS#:** _____
Last First MI

Home Address: _____
CITY STATE ZIP

Home #: (_____) _____ **Cell #:** (_____) _____ **Work #:** (_____) _____ **DL#:** _____

E-mail Address: _____ **When are the best times to reach you?** _____

Whom may we thank for inviting you? _____ **Other family members seen by us:** _____

Employer: _____ **How long there?** _____ **Occupation:** _____

Employer's Address: _____
CITY STATE ZIP

General Doctor: _____ **Previous or Present** (Please Circle) **Date of last visit:** _____

In the event of an emergency, whom should we contact?

His/Her Name: _____ **Relation:** _____

Home #: (_____) _____ **Work #:** (_____) _____ **Cell #:** (_____) _____

Spouse Information

His/Her Name: _____ **Birthdate:** ____/____/____ **SS#:** _____
Last First MI

Work #: (_____) _____ **Cell #:** (_____) _____

Person responsible for account, if other than yourself

His/Her Name: _____ **Relation:** _____ **SS #:** _____

Employer: _____ **Work #:** (_____) _____ **DL#:** _____

Home #: (_____) _____ **Billing Address:** _____
CITY STATE ZIP

Insurance Information

Insured's Name: _____ **Relation:** _____ **Birthdate:** ____/____/____ **SS#:** _____

Insured's Employer: _____ **Employer's Address:** _____
CITY STATE ZIP

Insurance Co. Name: _____ **Ins. Co. Ph #:** (_____) _____ **Group # (Plan, Local, or Policy):** _____

Insurance Co. Address: _____
CITY STATE ZIP

Do you have any additional insurance? ☐ **Yes** ☐ **No** **If yes, please complete the following:**

Insured's Name: _____ **Relation:** _____ **Birthdate:** ____/____/____ **SS#:** _____

Insured's Employer: _____ **Employer's Address:** _____
CITY STATE ZIP

Insurance Co. Name: _____ **Ins. Co. Ph #:** (_____) _____ **Group # (Plan, Local, or Policy):** _____

Insurance Co. Address: _____
CITY STATE ZIP

Patient Dental History

Name: _____ **Birthdate:** ____/____/____

Why have you come to the Doctor today? _____

Name of Previous Dentist and Location: _____ **Date of Last Exam:** _____

Are you currently in pain? ☐ Yes ☐ No **If yes, where?** _____

Are your teeth sensitive to hot or cold foods/liquids? ☐ Yes ☐ No

Are your teeth sensitive to sweet or sour foods/liquids? ☐ Yes ☐ No

Do you have any sores or lumps in or near your mouth? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No **If yes, for what condition?** _____

Do you ever experience a dry mouth? ☐ Yes ☐ No **If yes, when?** _____

Have you ever had any problems with dental treatment? ☐ Yes ☐ No

If yes, what was the problem? _____

Have you had any head, neck, or jaw injuries? ☐ Yes ☐ No

Have you ever experienced any of the following problems in your jaw?

Clicking ☐ Yes ☐ No

Pain ☐ Yes ☐ No

Difficulty in opening or closing ☐ Yes ☐ No

Difficulty in chewing ☐ Yes ☐ No

Do you have frequent headaches? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Have you had any orthodontic treatment? ☐ Yes ☐ No

Do your gums bleed when brushing or flossing? ☐ Yes ☐ No

Have you ever been told you have periodontal disease? ☐ Yes ☐ No

Do you have any mobility in your teeth? ☐ Yes ☐ No

Have you ever received oral hygiene instructions? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No **Do you Brush Daily?** ☐ Yes ☐ No

Type of bristles on toothbrush: ☐ Hard ☐ Medium ☐ Soft

Do you use anything in addition to your brush and floss? ☐ Yes ☐ No **If yes, what?** _____

Do you wear dentures or partials? ☐ Yes ☐ No **If yes, date of placement?** _____

Would you like whiter teeth? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ **DATE** _____

Doctor's Comments: _____

_____

_____

_____

_____ **SIGNATURE** _____ **DATE** _____

Patient Medical Health History

Name: _____ ☐ M ☐ F **Birthdate:** ____/____/____ **Age:** _____

Physician: _____ **Office Phone #:** (_____) _____ **Date of Last Exam:** _____

Are you under medical treatment now? ☐ Y ☐ N **If yes, please explain:** _____

Are you currently taking any medications, pills, or drugs? ☐ Y ☐ N **If yes, please list:** _____

_____

Have you ever been hospitalized or had a major operation? ☐ Y ☐ N **If yes, please explain:** _____

Have you ever had a serious head or neck injury? ☐ Y ☐ N **If yes, please explain:** _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Y ☐ N

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Y ☐ N

Are you on a special diet? ☐ Y ☐ N

Do you use tobacco? ☐ Y ☐ N

Do you use controlled substances? ☐ Y ☐ N

Women: are you
Pregnant/Trying to get pregnant? ☐ Y ☐ N **If yes, Week #:**_____ **Taking oral contraceptives?** ☐ Y ☐ N **Nursing?** ☐ Y ☐ N

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other **If yes, please explain:** _____

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

AIDS/HIV Positive	☐ Y ☐ N	Diabetes	☐ Y ☐ N	Hepatitis B or C	☐ Y ☐ N	Rheumatism	☐ Y ☐ N
Alzheimer's Disease	☐ Y ☐ N	Drug Addiction	☐ Y ☐ N	Herpes	☐ Y ☐ N	Scarlet Fever	☐ Y ☐ N
Anaphylaxis	☐ Y ☐ N	Easily Winded	☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N	Shingles	☐ Y ☐ N
Anemia	☐ Y ☐ N	Emphysema	☐ Y ☐ N	High Cholesterol	☐ Y ☐ N	Sickle Cell Disease	☐ Y ☐ N
Angina	☐ Y ☐ N	Epilepsy or Seizures	☐ Y ☐ N	Hives or Rash	☐ Y ☐ N	Sinus Trouble	☐ Y ☐ N
Arthritis/Gout	☐ Y ☐ N	Excessive Bleeding	☐ Y ☐ N	Hypoglycemia	☐ Y ☐ N	Spina Bifida	☐ Y ☐ N
Artificial Heart Valve	☐ Y ☐ N	Excessive Thirst	☐ Y ☐ N	Irregular Heartbeat	☐ Y ☐ N	Stomach/Intestinal Disease	☐ Y ☐ N
Artificial Joint	☐ Y ☐ N	Fainting Spells/Dizziness	☐ Y ☐ N	Kidney Problems	☐ Y ☐ N	Stroke	☐ Y ☐ N
Asthma	☐ Y ☐ N	Fibromyalgia	☐ Y ☐ N	Leukemia	☐ Y ☐ N	Swelling of Limbs	☐ Y ☐ N
Blood Disease	☐ Y ☐ N	Frequent Cough	☐ Y ☐ N	Low Blood Pressure	☐ Y ☐ N	Thyroid Disease	☐ Y ☐ N
Blood Transfusion	☐ Y ☐ N	Frequent Diarrhea	☐ Y ☐ N	Lung Disease	☐ Y ☐ N	Tonsilitis	☐ Y ☐ N
Breathing Problems	☐ Y ☐ N	Frequent Headaches	☐ Y ☐ N	Lupus	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N
Bruise Easily	☐ Y ☐ N	Glaucoma	☐ Y ☐ N	Mitral Valve Prolapse	☐ Y ☐ N	Tumors or Growths	☐ Y ☐ N
Cancer	☐ Y ☐ N	Hay Fever	☐ Y ☐ N	Osteoporosis	☐ Y ☐ N	Ulcers	☐ Y ☐ N
Chemotherapy	☐ Y ☐ N	Heart Attack/Failure	☐ Y ☐ N	Parathyroid Disease	☐ Y ☐ N	Valley Fever	☐ Y ☐ N
Chest Pains	☐ Y ☐ N	Heart Murmur	☐ Y ☐ N	Psychiatric Care	☐ Y ☐ N	Veneral Disease	☐ Y ☐ N
Cold Sores/Fever Blisters	☐ Y ☐ N	Heart Pacemaker	☐ Y ☐ N	Radiation Treatment	☐ Y ☐ N	West Nile Virus	☐ Y ☐ N
Congenital Heart Disorder	☐ Y ☐ N	Heart Trouble/Disease	☐ Y ☐ N	Recent Weight Loss	☐ Y ☐ N	Yellow Jaundice	☐ Y ☐ N
Convulsions	☐ Y ☐ N	Hemophilia	☐ Y ☐ N	Renal Dialysis	☐ Y ☐ N		
Cortisone Medicine	☐ Y ☐ N	Hepatitis A	☐ Y ☐ N	Rheumatic Fever	☐ Y ☐ N		

Have you ever had any serious illness not listed above? ☐ Y ☐ N _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ **DATE** _____

Doctor's Comments: _____

_____

_____

_____

_____ **SIGNATURE** _____ **DATE** _____