PATIENT INFORMATION

Name _____ Social Security Number _____

Home Address _____ _____
Apt# and Street City State Zip

Occupation _____ Date of Birth _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Gender: Male ____ Female _____ Referred by _____

Person Responsible For Account:

Name _____ Relationship _____

Address _____ _____
Apt# and Street City State Zip

Home Phone _____ Work Phone _____ Social Security Number _____

Person to Contact in case of Emergency:

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Person(s) Authorized to Receive Protected Health Information about You:

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Notice of Privacy Practices
The privacy of your health information is important to us. We are required by federal and state law to maintain the privacy of your health information. We are also required to provide you with a copy of our privacy practices, our legal duties, and your rights concerning your health information.
You may request a copy of our notice at any time. It is also available on our website www.jackwilsondmd.com.

Request for Confidential Communication
As my dental care provider, you may do the following with my permission:

	YES	NO		YES	NO
Contact me at home	□	□	Leave messages on my home voicemail/machine	□	□
Contact me via cell phone	□	□	Leave messages on my cell phone voicemail	□	□
Contact me at work	□	□	Leave messages on my work voicemail/machine	□	□
Contact me via e-mail	□	□	Leave text messages on my cell phone	□	□

DENTAL INSURANCE INFORMATION

We consider our relationship with you to be of primary importance. We will always make our recommendations to you based on what we believe is the very best treatment for you, regardless of your insurance coverage. As the patient, it is your responsibility to deal with your insurance company and your employer. We will file your claims and assist you in any way possible to maximize your dental insurance benefits, but we want to reemphasize that **we are not participating providers with any insurance companies** and that you are financially responsible for the fees charged in our office.

Primary Insurance Carrier _____ I.D. No _____

Insured or Employee's Name _____ Date of Birth _____

Employer _____ Group No. _____ Effective Date _____

□ I authorize the release of all necessary information to my insurance carrier.

□ I authorize payment directly to the provider.

□ I have read this form and agree to be financially responsible for all the fees regardless of the insurance coverage.

Signature _____ Date _____

FINANCIAL INFORMATION

Dental Insurance: We will file the insurance claims at no charge. You are responsible for the balance of the treatment fees not covered by insurance.

Payment Options: Visa, MasterCard, Discover Card and Care Credit is accepted for your convenience. A monthly 1.5% (18% annually) finance charge will be added to all unpaid balances over 90 days.

The undersigned agrees that the responsibility for payment of dental services rendered in this office for himself/herself or his/her dependents is his/hers. The undersigned also agrees that, in the event of default of this Agreement, this office shall be entitled to recover all costs of collection, including a reasonable fee for the services of an attorney.

_____ _____
Patient Date

_____ _____
Parent/Guardian Date

Office Hours

Monday - Friday 9:00 A.M. - 5:00 P.M. Lunch Hour 1:00 P.M. - 2:00 P.M.

We will make every effort to accommodate emergency patients. In case of an emergency after regular office hours, you can call our office and follow the instructions on the answering machine to get in touch with one of the dentists.

Appointment Cancellation

We ask that you give us 24 hours notice if you are unable to keep an appointment, otherwise a charge will be made for the time reserved for you. We understand, and will make exceptions, if you have an emergency or if we experience inclement weather.

MEDICAL HISTORY

Patient Name _____ Date of Birth _____

Name of Physician and their Specialty _____

Most RECENT Physical Examination _____ Purpose _____

CARDIOVASCULAR				**GASTROINTESTINAL**		
Heart Failure, or Cardiac Stent	Yes	No		Stomach or Duodenal Ulcer	Yes	No
History of Infective Endocarditis	Yes	No		Digestive Disorders (Celiac Disease or Gastric Reflux)	Yes	No
Artificial Heart Valve, Repaired Heart Defect	Yes	No		Jaundice	Yes	No
Pacemaker or Implantable Defibrillator	Yes	No		Hepatitis - Type _____	Yes	No
High or Low Blood Pressure	Yes	No		Liver Disease	Yes	No
Rheumatic or Scarlet Fever	Yes	No		Colitis	Yes	No
Irregular Heart Beat (Arrhythmia)	Yes	No		Persistent Diarrhea	Yes	No
Heart Murmur, Click or Mitral Valve Prolapse	Yes	No				
Any Other Heart Problems _____ _____	Yes	No		**RESPIRATORY**		
				Asthma	Yes	No
HEMATOLOGIC				Emphysema (shortness of breath)	Yes	No
Anemia or other Blood Disorder	Yes	No		Tuberculosis (TB)	Yes	No
Prolonged Bleeding due to slight cut (INR>3.5)	Yes	No		Breathing Problems, Sleep Apnea, Snoring)	Yes	No
Blood Transfusion	Yes	No		Persistent Cough, Bronchitis	Yes	No
Leukemia	Yes	No		Sinus Problems	Yes	No
Do you take Blood Thinners?	Yes	No				
High Cholesterol or taking Statin Drugs	Yes	No		**GENITO-URINARY**		
				Kidney or Bladder Problems	Yes	No
NEURAL				Dialysis	Yes	No
Stroke or Transient Ischemia Attack	Yes	No		STD/STI/HPV	Yes	No
Epilepsy, Seizures, Fainting or Convulsions	Yes	No		HIV/AIDS	Yes	No
Neurological Disorders (ADD/ADHD, Prion Disease)	Yes	No		MALE-Prostate Disorders	Yes	No
Head or Neck Injuries	Yes	No				
Glaucoma, Cataract, Contact Lenses	Yes	No		**OTHER CONDITIONS**		
Frequent Headaches or Migraines	Yes	No		Use Tobacco, Smokeless Tobacco, or have you Smoked Previously	Yes	No
Psychiatric Treatment	Yes	No		Use Dietary Supplements	Yes	No
Anxiety or Depression	Yes	No		Take Medication for Weight Management	Yes	No
				Use Alcohol	Yes	No
ENDOCRINE				Take Recreational Drugs	Yes	No
Diabetes	Yes	No		Take Antidepressant Drugs	Yes	No
Thyroid, Parathyroid Disease, Calcium Deficiency	Yes	No		Enlarged Lymph Node or Gland	Yes	No
Autoimmune Disease, i.e. Rheumatoid Arthritis, Lupus, Scleroderma, etc.	Yes	No		Tumor or Cancer	Yes	No
Viral Infections and Cold Sores	Yes	No		Radiation or Chemotherapy	Yes	No
Hormone Deficiency	Yes	No		Take Immunosuppressive Medication	Yes	No
				FEMALE - Take Birth Control Pills	Yes	No
DERMAL/ORAL/MUSCULOSKELETAL				FEMALE - Pregnant or Possibly Pregnant	Yes	No
Arthritis, Rheumatism or Gout	Yes	No		FEMALE - Nursing	Yes	No
Hives, Skin Rash or Hay Fever	Yes	No		Aware of Change in your Health in last 24 hours (i.e. fever, chills, new cough, frequent urination, diarrhea)	Yes	No
Artificial Joint	Yes	No				
Osteoporosis/ Osteopenia- taking bisphosphonates	Yes	No				
Any Lumps or Swelling in the Mouth	Yes	No		ARE YOU PRESENTLY BEING TREATED FOR ANY OTHER ILLNESS	Yes	No

ALLERGIES

Do You Have or Have You Ever Had an Allergic reaction To:

Penicillin	Yes	No	Erythromycin	Yes	No
Aspirin, Ibuprofen, Acetaminophen, Codeine	Yes	No	Tetracycline	Yes	No
Sulfa	Yes	No	Local Anesthetic	Yes	No
Fluoride	Yes	No	Metals (nickel, gold, silver, _____)	Yes	No
Latex	Yes	No	Other _____	Yes	No

Describe any current medical treatment, impending surgery, genetic/developmental delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injection, etc.)

_____

_____

List all medications, supplements, and/or vitamins you are presently taking and the purpose for taking it:

MEDICATION/DOSAGE	REASON	MEDICATION/DOSAGE	REASON

Please advise us in the future of any change in your medical history or any medications you may be taking.

Patient/Guardian Signature: _____ Date:_____

Doctor's Signature _____ Date _____

FOR OFFICE USE ONLY

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DENTAL HISTORY

Previous Dentist _____ Date of Most Recent Exam _____ and X-Rays _____

What is your Immediate Concern? _____

PERSONAL HISTORY

Are you fearful of dental treatment?	Yes	No
Have you had an unfavorable dental experience?	Yes	No
Have you ever had complications from past dental treatment?	Yes	No
Have you ever had trouble getting numb or had any reactions to local anesthetic?	Yes	No
Did you ever have braces, orthodontic treatment or had your bite adjusted?	Yes	No
Have you had any teeth removed?	Yes	No

GUM AND BONE

Do your gums bleed or are they painful when brushing or flossing?	Yes	No
Have you ever been treated for gum disease or been told you have lost bone around your teeth?	Yes	No
Have you ever noticed an unpleasant odor or taste in your mouth?	Yes	No
Is there anyone with a history of periodontal disease in your family?	Yes	No
Have you ever experienced gum recession?	Yes	No
Have you experienced a burning sensation in your mouth?	Yes	No

TOOTH STRUCTURE

Have you had any cavities within the last 3 years?	Yes	No
Does the amount of saliva in your mouth feel too little or do you have difficulty swallowing food?	Yes	No
Are your teeth sensitive to hot, cold or sweets or do you avoid brushing any part of your mouth?	Yes	No
Do you frequently get food caught between any teeth?	Yes	No

BITE AND JAW JOINT

Do you have problems with your jaw joint? (pain, limited opening, locking, popping, difficulty chewing hard or dry foods?	Yes	No
Have your teeth changed in the last 5 years, becoming shorter, thinner, worn, crooked, or overlapped?	Yes	No
Are your teeth developing spaces or becoming more loose?	Yes	No
Do you have more than one bite position, squeeze, or shift your jaw to make your teeth fit together?	Yes	No
Do you chew ice, bite your nails, use your teeth to hold objects, place your tongue between your teeth, or have any other oral habits?	Yes	No
Do you clench your teeth in the daytime or make them sore?	Yes	No
Do you have any problems with sleep, wake up with a headache or an awareness of your teeth or jaw?	Yes	No
Do you wear or have you ever worn a bite appliance?	Yes	No
Do you wear denture(s) and when was the most recent denture(s) made Date:	Yes	No

SMILE CHARACTERISTICS

Is there anything about the appearance of your teeth that you would like to change?	Yes	No
Have you ever whitened (bleach) your teeth?	Yes	No
Have you been disappointed with the appearance of previous dental work?	Yes	No

Patient/Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____