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 ____

Date of Most RECENT Physical Examination _________________________

CARDIOVASCULAR		
Heart Failure	Yes	No
Arterial or Cardiac Stent	Yes	No
History of Infective Endocarditis	Yes	No
Artificial Heart Valve	Yes	No
Repaired or Unrepaired Heart Defect	Yes	No
If yes, explain _________________________		
Pacemaker, Implanted Defibrillator (circle which)	Yes	No
High or Low Blood Pressure (circle which)	Yes	No
Irregular Heart Beat (Arrhythmia)	Yes	No
Heart Murmur, Mitral Valve Prolapse (circle which)	Yes	No
Any Other Heart Problems __________________	Yes	No
HEMATOLOGIC		
Anemia	Yes	No
Blood disorder; if yes, explain___________________	Yes	No
Do you take Blood Thinners?	Yes	No
Leukemia	Yes	No
High Cholesterol	Yes	No
NEURAL		
Stroke or Transient Ischemia Attack	Yes	No
Epilepsy, Seizures	Yes	No
ADD/ADHD	Yes	No
Head or Neck Injuries	Yes	No
Glaucoma, Cataracts (circle which)	Yes	No
Frequent Headaches or Migraines	Yes	No
Psychiatric Treatment	Yes	No
Anxiety or Depression (circle which)	Yes	No
ENDOCRINE	Yes	No
Diabetes- Type______	Yes	No
Hypo- or hyper-thyroid disease (circle which)		
Autoimmune Disease, i.e. Rheumatoid Arthritis, Lupus, etc.; if yes, which? ___________________	Yes	No
Cold Sores	Yes	No
Hormone Deficiency	Yes	No
DERMAL/ORAL/MUSCULOSKELETAL		
Osteoarthritis	Yes	No
Artificial Joint	Yes	No
If yes, did your orthopedist recommend antibiotics prior to dental treatment?	Yes	No
Osteoporosis/ Osteopenia	Yes	No
Do you currently or have you ever taken bisphosphonates? (i.e. Boniva, Actonel, etc.)	Yes	No

GASTROINTESTINAL		
Stomach or Intestinal Ulcer	Yes	No
Gastric reflux (GERD)	Yes	No
Digestive Disorder (Celiac Dx, Colitis)	Yes	No
Hepatitis - Type _____	Yes	No
Liver Disease	Yes	No
Persistent Diarrhea	Yes	No
RESPIRATORY	Yes	No
Asthma	Yes	No
Emphysema	Yes	No
Tuberculosis (TB)	Yes	No
Chronic Sinus or Breathing Problems	Yes	No
Sleep Apnea, Snoring (circle which)	Yes	No
Persistent Cough, Bronchitis (circle which)	Yes	No
GENITO-URINARY		
Kidney or Bladder Problems (circle which)	Yes	No
Dialysis	Yes	No
STD, HPV (circle which)	Yes	No
HIV/AIDS	Yes	No
MALE-Prostate Disorders	Yes	No
OTHER CONDITIONS		
Tobacco use, current or previous	Yes	No
If yes, what kind? _______________		
When/how long? ________________		
E-cigarette use	Yes	No
Alcohol consumption	Yes	No
If yes, how many drinks/wk? ______		
Recreational Drugs	Yes	No
If yes, explain _________________		
Botox	Yes	No
Enlarged Lymph Nodes or Glands	Yes	No
Tumor or Cancer	Yes	No
If yes, what kind and when? ____________________________		
Radiation or Chemotherapy (circle which)	Yes	No
Health changes in the last 24 hrs (i.e. fever, chills, etc.); if yes, explain_____________	Yes	No
ARE YOU PRESENTLY BEING TREATED FOR ANY OTHER ILLNESS	Yes	No
If yes, explain: ________________ ____________________________		
FEMALE – Pregnant, Possibly Pregnant, Nursing (circle which)	Yes	No

ALLERGIES

Do You Have or Have You Ever Had an Allergic reaction (anaphylaxis/trouble breathing or hives/itching) to:

Penicillin	Yes	No	Erythromycin	Yes	No
Aspirin	Yes	No	Tetracycline	Yes	No
Sulfa	Yes	No	Local Anesthetic	Yes	No
Acetaminophen (Tylenol)	Yes	No	Fluoride	Yes	No
Ibuprofen (Advil, Motrin)	Yes	No	Metals (nickel, gold, silver, ___________)	Yes	No
Codeine	Yes	No	Other _______________________________		
Latex	Yes	No			

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:**________________________________

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 ever had complications from past dental treatment?	Yes	No
Do you consistently have trouble getting numb or have bad reactions to local anesthetic?	Yes	No

GUM AND BONE

Have you ever been treated for gum disease or been told you have lost bone around your teeth?	Yes	No
Is there anyone with a history of periodontal disease (gum disease, pyria) in your family?	Yes	No
Have you ever experienced gum recession?	Yes	No
Any lumps or swelling in your mouth?	Yes	No

TOOTH STRUCTURE

Have you had any cavities within the last 3 years?	Yes	No
Does your mouth always feel dry?	Yes	No
Are your teeth sensitive to hot, cold or sweets?	Yes	No
Do you frequently get food caught between any teeth?	Yes	No

BITE AND JAW JOINT

Do you have pain with your jaw joint?	Yes	No
Do you have noise or clicking in your jaw?	Yes	No
Do you wear or have you ever worn a biteguard?	Yes	No

SMILE CHARACTERISTICS

Is there anything about the appearance of your teeth that you would like us to address? If yes, explain____	Yes	No

Patient/Guardian Signature: ____ **Date:** _________________________