

JACK T. WILSON, III, DMD
LAURA H. FIZER, DMD

PATIENT INFORMATION

Name _____ Social Security Number _____

Home Address _____
Apt# and Street _____ City _____ State _____ Zip _____

Occupation _____ Date of Birth _____ Gender _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ 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 _____ Phone _____

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

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Request for Confidential Communication

As my dental care provider, you have my permission to:

Leave messages with appointment details via:	YES	NO
Home voicemail/machine	<input type="checkbox"/>	<input type="checkbox"/>
Cell phone voicemail	<input type="checkbox"/>	<input type="checkbox"/>
Text messages	<input type="checkbox"/>	<input type="checkbox"/>
Work voicemail/machine	<input type="checkbox"/>	<input type="checkbox"/>
*Email	<input type="checkbox"/>	<input type="checkbox"/>

***Communicate only with other healthcare providers, insurance companies and authorized individuals through both encrypted and non encrypted emails.**

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.

Please sign:

I have been informed of my rights to receive or decline a copy of the office's Notice of Privacy Practices, including the practices communication policy above.

Name: _____ Date: _____

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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

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.

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MEDICAL HISTORY

Patient Name _____

Date of Birth _____

Name of Physician and their Specialty _____

Date of Most RECENT Physical Examination _____

CARDIOVASCULAR			GASTROINTESTINAL		
Heart Failure	Yes	No	Stomach or Intestinal Ulcer	Yes	No
Arterial or Cardiac Stent	Yes	No	Gastric reflux (GERD)	Yes	No
History of Infective Endocarditis	Yes	No	Digestive Disorder (Celiac Dx, Colitis)	Yes	No
Artificial Heart Valve	Yes	No	Hepatitis - Type _____	Yes	No
Repaired or Unrepaired Heart Defect	Yes	No	Liver Disease	Yes	No
If yes, explain _____			Persistent Diarrhea	Yes	No
Pacemaker, Implanted Defibrillator (circle which)	Yes	No	RESPIRATORY	Yes	No
High or Low Blood Pressure (circle which)	Yes	No	Asthma	Yes	No
Irregular Heart Beat (Arrhythmia)	Yes	No	Emphysema	Yes	No
Heart Murmur, Mitral Valve Prolapse (circle which)	Yes	No	Tuberculosis (TB)	Yes	No
Any Other Heart Problems _____	Yes	No	Chronic Sinus or Breathing Problems	Yes	No
HEMATOLOGIC			Sleep Apnea, Snoring (circle which)	Yes	No
Anemia	Yes	No	Persistent Cough, Bronchitis (circle which)	Yes	No
Blood disorder; if yes, explain _____	Yes	No	GENTO-URINARY		
Do you take Blood Thinners?	Yes	No	Kidney or Bladder Problems (circle which)	Yes	No
Leukemia	Yes	No	Dialysis	Yes	No
High Cholesterol	Yes	No	STD, HPV (circle which)	Yes	No
NEURAL			HIV/AIDS	Yes	No
Stroke or Transient Ischemia Attack	Yes	No	MALE-Prostate Disorders	Yes	No
Epilepsy, Seizures	Yes	No	OTHER CONDITIONS		
ADD/ADHD	Yes	No	Tobacco use, current or previous	Yes	No
Head or Neck Injuries	Yes	No	If yes, what kind? _____		
Glaucoma, Cataracts (circle which)	Yes	No	When/how long? _____		
Frequent Headaches or Migraines	Yes	No	E-cigarette/ vape pen	Yes	No
Psychiatric Treatment	Yes	No	Alcohol consumption	Yes	No
Anxiety or Depression (circle which)	Yes	No	If yes, how many drinks/wk? _____		
ENDOCRINE			Recreational Drugs	Yes	No
Diabetes- Type _____	Yes	No	If yes, explain _____		
Hypo- or hyper-thyroid disease (circle which)			Botox	Yes	No
Autoimmune Disease, i.e. Rheumatoid Arthritis,	Yes	No	Enlarged Lymph Nodes or Glands	Yes	No
Lupus, etc.; if yes, which? _____			Tumor or Cancer	Yes	No
Cold Sores	Yes	No	If yes, what kind and when?		
Hormone Deficiency	Yes	No	_____		
DERMAL/ORAL/MUSCULOSKELETAL			Radiation or Chemotherapy (circle which)	Yes	No
Osteoarthritis	Yes	No	Health changes in the last 24 hrs (i.e. fever, chills, etc.); if yes, explain _____	Yes	No
Artificial Joint	Yes	No	ARE YOU PRESENTLY BEING TREATED FOR ANY OTHER ILLNESS	Yes	No
If yes, did your orthopedist recommend antibiotics prior to dental treatment?	Yes	No	If yes, explain: _____		
Osteoporosis/ Osteopenia	Yes	No	_____		
Do you currently or have you ever taken bisphosphonates? (i.e. Boniva, Actonel, etc.)	Yes	No	FEMALE – Pregnant, Possibly Pregnant, Nursing (circle which)	Yes	No

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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:** _____

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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 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
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Patient/Guardian Signature: _____ **Date:** _____