



Dr. Susan K. Wilson
Patient Questionnaire

BASIC INFORMATION

First Name: _____ **Middle Initial:** _____ **Last Name:** _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Home Phone: _____ **Cell Phone:** _____
Email: _____
Appointment Confirmation Preference: Telephone Email Both **(please circle)**
Birthdate: _____ **(MM/DD/YYYY)** **Age:** _____ **SSN#:** _____
Sex: M/ F **(please circle)** **Marital Status:** Single, Married, Separated, Divorced, Widowed **(please circle)**
Physician Name: _____ **Phys Phone:** _____
Preferred Pharmacy: _____ **Pharm Phone:** _____
*****Do you require pre-medication prior to your dental treatment (i.e. antibiotic)?** Yes No
Emergency Contact: _____ **Relationship** _____ **Phone:** _____
Employment Status: Full Time, Part Time, Self-Employed, Retired, Other _____ **(please circle)**

RESPONSIBLE PARTY

First Name: _____ **Middle Initial:** _____ **Last Name:** _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Home Phone: _____ **Cell Phone:** _____
Email: _____
Birthdate: _____ **SSN#:** _____ **Relationship to patient:** _____
 Primary Insurance Holder **Secondary Insurance Holder**

INSURANCE INFO

Insurance Co. Name: _____ **Phone:** _____
Subscriber Name: _____ **Subscriber Birthdate:** _____
Subscriber ID or SSN# _____ **Patient Relationship:** Self, Spouse, Dependent
Address (if different from patient) _____
City, State, Zip _____
Subscriber Employer: _____ **City, State:** _____
More than one Insurance? Yes or No If yes, **Secondary Ins. Co. Name** _____
Subscriber Name, Birthdate, SSN/ ID, Employer: _____

*Please provide the receptionist with your **insurance card** (if applicable) and a current **photo ID**.

Are you currently under the care of a physician?	Yes	No
Have you ever been hospitalized or had a major operation?	Yes	No
Have you ever had a serious head or neck injury?	Yes	No
Are you taking any medications, vitamins or nutritional supplements? (Please list below)	Yes	No
Have you ever taken Fosamax, Boniva, Actonel or an other medications containing biophosphates?	Yes	No
Are you on a special diet?	Yes	No
Do you use tobacco?	Yes	No
Do you use controlled substances (including Marijuana (Cannabis))?	Yes	No
Have you ever worn braces (traditional or Invisalign ®)?	Yes	No
Do you often notice an unpleasant taste in your mouth?	Yes	No

If you answered "yes" to any of the above questions, please explain as completely as possible below:

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Are you allergic to any of the following? (Please circle all that apply)
 Aspirin; Penicillin; Codeine; Sulfa Drugs; Acrylic; Metal; Latex; Local Anesthetics; Other _____

WOMEN: ARE YOU...
pregnant/ trying to get pregnant? Yes No **Taking oral contraceptives?** Yes No **Nursing?** Yes No

Do you have, or have you had ANY of the following? (please circle all that apply to you)

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

Have you ever had a serious illness that is not listed above? Yes No If yes, please explain _____

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

*Signature of Patient, Parent or Guardian _____ Date _____