SARAH C. WILMER, DDS, PLLC
PATIENT INFORMATION

Welcome to our office! To assist us in serving you,
Please complete the following confidential form.
The information provided is important to your dental health.

Patient's name _____
Preferred name _____
Date of Birth _____
If minor, guardian's name _____
Social Security # _____

Home phone _____ Work phone _____ Cell phone _____

Mailing address _____
City _____State _____ Zip _____

Employer _____
Occupation _____
EMAIL ADDRESS: _____

NAMES OF FAMILY MEMBERS WHO ARE PATIENTS HERE:
_____
NEW PATIENTS: WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?
_____

PREFERRED METHOD OF CONTACT : ❑**PHONE** ❑**E-MAIL** ❑**TEXT**

❑FEMALE ❑MALE ❑OTHER_____

❑SINGLE ❑ MARRIED ❑ PARTNERED ❑ DIVORCED ❑ SEPARATED ❑WIDOWED

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT? _____
_____

MEDICAL HEALTH HISTORY

Are you in good health? Yes No
Has there been any change in your general health in the past year? Yes No
Date of last physical exam_____
Are you now under a physician's care for a particular problem? Yes No
Have you ever had any serious illnesses, operations or hospitalizations? Yes No
If so, describe._____ _____
In the past year? Yes(describe)_____No
Do you have any total joint replacements?Type?_____When?_____No
Height_____ Weight_____

Do you have <u>or</u> have you HAD any of the following? (Please check/explain all that apply)

- ❑ Cancer or tumor _____
  - ❑ Radiation _____
  - ❑ Chemotherapy _____
  - ❑ Other _____
- ❑ Cardiovascular Disease
- ❑ Heart attack
- ❑ Angina
- ❑ Heart murmur
- ❑ Congenital Heart Disease
- ❑ Coronary Artery Disease
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ High Cholesterol
- ❑ Stroke
- ❑ Palpitations
- ❑ Heart surgery
- ❑ Pacemaker
- ❑ Mitral valve prolapse
  - ❑ WITH or WITHOUT regurgitation
- ❑ Heart defect _____
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Other _____
- ❑ Artificial joint or valve (month and year)_____
- ❑ Heart valve
- ❑ Hip
- ❑ Knee
- ❑ Other _____
- ❑ Lung Disease
- ❑ Asthma
- ❑ COPD
- ❑ Emphysema
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Shortness of Breath
- ❑ Chest Pain
- ❑ Severe Coughing
- ❑ Other _____
- ❑ Kidney disease _____
- ❑ Liver disease
- ❑ Hepatitis
- ❑ Jaundice
- ❑ Other _____
- ❑ Alcoholism
- ❑ Chemical Dependency
- ❑ Recreational Drug Use (type?) _____
- ❑ Blood transfusion (year?) _____
- ❑ Diabetes (type?) _____

  If yes, last Hba1c and blood sugar readings?_____
- ❑ Thyroid Disease
- ❑ Hyperthyroid
- ❑ Hypothyroid
- ❑ Goiter
- ❑ Grave's
- ❑ Other _____
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, dizziness, fainting spells
- ❑ Restless Leg Syndrome
- ❑ Alzheimer's
- ❑ Bell's Palsy
- ❑ Cerebral Palsy
- ❑ Dementia
- ❑ Parkinson's
- ❑ Other _____
- ❑ Mental Health
- ❑ Depression
- ❑ Anxiety
- ❑ Bipolar
- ❑ Eating Disorder
  - ❑ Bulemia
  - ❑ Anorexia

- ❑ Other _____

- ❑ Arthritis
- ❑ Rheumatoid
- ❑ Osteoarthritis
- ❑ Psoriatic Arthritis
- ❑ Other _____

- ❑ Other Autoimmune Disease
- ❑ Lupus
- ❑ Raynaud Phenomenon
- ❑ Sjögren's Syndrome
- ❑ Other _____

- ❑ Venereal Diseases
- ❑ Herpes
- ❑ HPV
- ❑ Chlamydia
- ❑ Gonorrhea
- ❑ Syphilis
- ❑ Other _____

- ❑ Cold Sores
- ❑ Glaucoma
- ❑ Hearing Loss

- ❑ Digestive Tract
- ❑ IBS/IBD
- ❑ GERD
- ❑ Chrohns
- ❑ Colitis
- ❑ Other _____

- ❑ Blood Disorders
- ❑ Anemia
  - ❑ Iron Deficiency
  - ❑ Sickle-Cell
- ❑ AIDS or HIV positive
- ❑ Bleeding Disorder
  - ❑ Hemophilia
  - ❑ Von Willebrands
  - ❑ Other _____

- ❑ Dermatologic
- ❑ Eczema
- ❑ Rosacea
- ❑ Psoriasis
- ❑ Other _____

- ❑ Migraine headaches
- ❑ frequent headaches

- ❑ Hay fever
- ❑ Sinus trouble

- ❑ Seasonal allergies
- ❑ Hives

- ❑ Do you smoke? ❑ Yes ❑ No
  - ❑ If yes, how much _____
- ❑ Do you use chewing tobacco? ❑ Yes ❑ No
  How much? _____
- ❑ Have you had any serious problems related to previous dental treatment? _____
- ❑ Clicking or popping of the jaw?
- ❑ How long has it been since you've seen a dentist? _____
- ❑ How often do you brush? _____
- ❑ How often do you floss? _____
- ❑ Reason for your visit today _____

Are you **allergic** to, or have you reacted adversely to any of the following? Please list **reaction**.

- ❑ Latex materials_____
- ❑ Penicillin _____
- ❑ Other Antibiotics _____
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine _____
- ❑ Other pain killers_____
- ❑ Sulfa drugs _____
- ❑ Barbiturates, sedatives, or sleeping pills_____
- ❑ Aspirin_____
- ❑ Ibuprofen_____
- ❑ Foods _____
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin, Motrin, Aleve, Ibuprofen
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics _____
- ❑ Sulfa drugs
- ❑ High blood pressure medication _____
  Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin, Digitalis, or Inderal
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
  - ❑ Fosamax
  - ❑ Other bisphosphonates _____

- Other:_____
  _____
  _____

Women:

- May be pregnant
  Expected delivery date: _____
- Taking hormones or contraceptives

***If you are using Oral Contraceptives,** it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use an alternate form of birth control for one complete cycle of birth control pills after the course of antibiotics and other medication is completed. Please consult with your physician for further guidance.

Do you have a family history of:

- Diabetes
- Heart Disease
- Stroke
- High Cholesterol
- High Blood Pressure
- Cancer
- Periodontal/Gum disease
- Cavities
- Extractions
- Sleep Apnea
- Other_____

_____

Name and phone number of your physician:_____

Do you have any disease, condition, or problem not listed above?

_____

Please **list your medications** (prescribed and over the counter), including vitamins:

_____

_____

_____

Please add anything else you would like us to know:

_____

_____

Have you been out of the country in the last 6 Months? Yes No

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Patient/Guardian Signature _____ Date _____

BILLING, CREDIT, AND INSURANCE INFORMATION:

❑ **Self-Pay**

❑ **Concierge In-House Quality Dental Savings Plan**

❑ **Primary Insurance Information**

Subscriber's Name _____
Subscriber's Date of Birth _____
Subscriber's Social Security number _____
Subscriber's Dental Insurance Co._____
Subscriber's Group number_____
Subscriber's Employer _____

❑ **Secondary Insurance Information**

Subscriber's Name _____
Subscriber's Date of Birth _____
Subscriber's Social Security number _____
Subscriber's Dental Insurance Co._____
Subscriber's Group number_____
Subscriber's Employer _____

Payments of Professional fees are required at the time of service. 1 ½% will be added per month to any balance not paid in full within 30 days. Our office files with insurance companies as a courtesy to our patients, however, we cannot guarantee payment or participation. I understand that I am responsible for any amount not covered by my insurance. If the payment for these services is not made as agreed upon, I agree that I become responsible to pay all the costs of collecting the amount due which may include attorney fees of 33 1/3% , court cost and/or collection agency fees. Initials _____

I hereby authorize Sarah C. Wilmer, DDS, PLLC to furnish information to insurance carriers concerning treatment and I hereby assign to the corp./dentist all payments for dental services rendered to my dependents or me. Initials _____

We ask that you provide us with at least 24 hours' notice of cancellation for any appointments. We reserve the right to charge $50.00 per scheduled hour that is missed without such notice.

Initials _____

I acknowledge that I have been shown the Private Practices notice and may request a printed copy at any time. Initials _____

Signature of patient (or guardian) _____ Date _____