

Wilson Dental, PC (SYRACUSE)

224 S. Geddes St

Syracuse, NY 13204

Ph # : 315-423-9900

Fax # : 315-423-9901

Patient Personal Information

Title	Preferred Name	Birth Date	Age
Last, First		Marital Status	Sex
Address		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		Emergency Contact	Emergency Phone #
Email		Student	SSN
Health Care Guardian Name		School Name	
Health Care Guardian Phone #		Referral Type	

Person responsible/guarantor for paying bills

Title	Preferred Name	Birth Date	Age
Last, First		Marital Status	Sex
Address		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		SSN	
Email			

Do you have Primary Dental Insurance? __ Yes __ No

Do you have Primary Dental Insurance? __ Yes __ No		Do you have Secondary Dental Insurance? __ Yes __ No	
Group No/Name		Group No/Name	
Insurance Name		Insurance Name	
Phone #		Phone #	
Employer Name		Employer Name	
Subscriber Last, First		Subscriber Last, First	
Subscriber Address		Subscriber Address	
City, State, Zip		City, State, Zip	
Relationship to Patient	Birth Date	Relationship to Patient	Birth Date
Subscriber ID		Subscriber ID	

Patient Medical Information

MEDICATION ALLERGIES:	<input type="checkbox"/> Y <input type="checkbox"/> N Sulfa Drugs	<input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Tumor or Growth	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure
<input type="checkbox"/> Y <input type="checkbox"/> N Medication Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Other allergy	<input type="checkbox"/> Y <input type="checkbox"/> N Cardiac Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement
<input type="checkbox"/> Y <input type="checkbox"/> N Amoxicillin	MEDICAL HISTORY	<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy or Radiation	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney
<input type="checkbox"/> Y <input type="checkbox"/> N Aspirin	<input type="checkbox"/> Y <input type="checkbox"/> N Pregnant currently	<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N Leukemia
<input type="checkbox"/> Y <input type="checkbox"/> N Clindamycin	<input type="checkbox"/> Y <input type="checkbox"/> N ADHD	<input type="checkbox"/> Y <input type="checkbox"/> N Congestive Heart Failure	<input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Codeine	<input type="checkbox"/> Y <input type="checkbox"/> N Alcohol/Drug Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N Damaged Heart Valve	<input type="checkbox"/> Y <input type="checkbox"/> N Lung Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin	<input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Infection	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Mental Health Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Epinephrine	<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy/Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N Metal plates/screws/pins/rods
<input type="checkbox"/> Y <input type="checkbox"/> N Hydrocodone	<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells or hypotension	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse
<input type="checkbox"/> Y <input type="checkbox"/> N Iodine or dyes	<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N Gag Reflex	<input type="checkbox"/> Y <input type="checkbox"/> N Premedicate
<input type="checkbox"/> Y <input type="checkbox"/> N Latex Rubber	<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N Seasonal Allergies or Hayfever
<input type="checkbox"/> Y <input type="checkbox"/> N Local Anesthetics	<input type="checkbox"/> Y <input type="checkbox"/> N Autism	<input type="checkbox"/> Y <input type="checkbox"/> N Heart / Cardio Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke
<input type="checkbox"/> Y <input type="checkbox"/> N Metals	<input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune Disease or Lupus	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Sleep Apnea
<input type="checkbox"/> Y <input type="checkbox"/> N Penicillin	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Clotting Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems

Additional Comments

Dental Questionnaire

Dental History

Name of previous Dentist:

Address & Phone:

Reason for leaving?

Date of your last cleaning & exam:

Date of last X-rays:

Have you been Referred?

If so, what are you being referred for?

Name of Referring Dentist:

Address & Phone:

Dental Questions

Are you having any pain, swelling or urgent dental need today?

Do you have dental fear or anxiety?

Do your gums bleed while brushing or flossing ?

Are your teeth sensitive to hot, cold or sweets ?

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ?

Do you chew/smoke tobacco or vape in any form ?

Have you had any head, neck or jaw injuries ?

Any popping, clicking or soreness of the jaw or difficulty opening your mouth widely?

Have you ever had burning of the tongue or cracking of the corners of your mouth?

Do you clench or grind your teeth ?

Have you ever had orthodontic treatment (Braces)? If so date started:

Do you wear dentures or partials? Is so date of placement:

Any problems with your dentures?

Are you happy with your smile ?

Do you have problems with teeth/fillings breaking ?

Do you regularly use dental floss ?

Do you have, or have you ever been told, that you have Pyorrhea (Periodontal Disease) ?

Do you have an unpleasant taste or odor in your teeth/mouth ?

Does food catch between your teeth ?

Any Additional Dental history information:

Medical Questionnaire

Emergency Contact

Emergency Contact name & Relationship: _____

Emergency Contact Phone: _____

Medical Questionnaire

Family Physician _____

Address & Phone _____

Are you currently under care of a Physician ? If so what conditions: _____

Have you had any serious illness, operation or been hospitalized? If so for what conditions & dates: _____

Have you had covid? _____

If yes, when? _____

Are you currently taking any medication?
If you take many meds, please bring list _____

If Yes, what? _____

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) _____

Do you use alcoholic beverages ? _____

Do you smoke ? _____

Any Disease, Condition or Problem not Listed ? Please list _____

Women Only

Are you pregnant? _____

If Yes, what is your due date ? _____

Are you currently nursing ? _____

Are you on birth control pills / fertility drugs ? _____

Pharmacy preference

Pharmacy Name _____

Pharmacy location - Street & City _____

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature

Date

Dentist Signature

Date