Wilson Dental, PC (ROCHESTER)
728 E. Ridge. Rd
Rochester, NY 14621
Ph # : 607-238-1280

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 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:

- ☐ Y ☐ N Medication Allergies
- ☐ Y ☐ N Amoxicillin
- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Clindamycin
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Epinephrine
- ☐ Y ☐ N Hydrocodone
- ☐ Y ☐ N Iodine or dyes
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Other allergy

MEDICAL HISTORY

- ☐ Y ☐ N Pregnant currently
- ☐ Y ☐ N ADHD
- ☐ Y ☐ N Alcohol/Drug Abuse
- ☐ Y ☐ N AIDS/HIV Infection
- ☐ Y ☐ N Abnormal Bleeding
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Autism
- ☐ Y ☐ N Autoimmune Disease or Lupus
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Chemotherapy or Radiation
- ☐ Y ☐ N Congenital Heart Defect
- ☐ Y ☐ N Congestive Heart Failure
- ☐ Y ☐ N Damaged Heart Valve
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Epilepsy/Seizures
- ☐ Y ☐ N Fainting Spells or hypotension
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart / Cardio Disease
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Hepatitis
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Kidney
- ☐ Y ☐ N Leukemia
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Lung Disease
- ☐ Y ☐ N Mental Health Problems
- ☐ Y ☐ N Metal plates/screws/pins/rods
- ☐ Y ☐ N Mitral Valve Prolapse
- ☐ Y ☐ N Premedicate
- ☐ Y ☐ N Seasonal Allergies or Hayfever
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Sleep Apnea
- ☐ Y ☐ 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**