Wilson and Fiquett, D.M.D., P.C.

www.wfdental.net
office@wilsonfiquettdental.com
P.O. Box 681329 | 110 23rd St NW • Fort Payne, AL 35967
(256)845-0765

Medical History

Patient Name:

Last _____ First _____ MI _____

Preferred Name _____

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ AIDS
- ☐ Allergies
- ☐ Amox. Allergy
- ☐ Amoxicillin
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Anti Inflamm. Allerg
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ ArtificialHeartValve
- ☐ Aspirin Allergy
- ☐ Asthma
- ☐ Augmentin Allergy
- ☐ Beta Blocker
- ☐ Bleeding Problems
- ☐ Blood Transfusion
- ☐ BLOODTHINNER
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Clindamycin Allergy
- ☐ Codeine Allergy
- ☐ Diabetes
- ☐ Doxycycline allergy
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ EPI ALLERGY
- ☐ Epilepsy or Seizures
- ☐ Epinephrine ALLERGY
- ☐ Erythromycin allergy
- ☐ Fainting/Dizziness
- ☐ Fever Blisters
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Heart Murmur/MVP
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Ibuprofen Allergy
- ☐ Iodine allergies
- ☐ Jaundice
- ☐ Keflex allergy
- ☐ Kidney Trouble
- ☐ LATEX ALLERGY
- ☐ Liver Disease
- ☐ MORPHINE
- ☐ Morphine allergy
- ☐ Nervousness
- ☐ Other
- ☐ Pain in Jaw Joints
- ☐ Penicillin Allergy
- ☐ PHENERGAN allergies
- ☐ Pregnancy
- ☐ Pre-Med
- ☐ Psychiatric Tx
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Sulfa allergies
- ☐ sulfa Allergy
- ☐ Surgery
- ☐ Thyroid disorder/dz
- ☐ Tuberculosis
- ☐ Ultram
- ☐ Venereal Disease

- ☐ Ever been hospitalized (illness or injury)
- ☐ Presently being treated for any other illnesses
- ☐ Subject to frequent headaches
- ☐ Tobacco/Alcohol Use
- ☐ FEMALE: Taking birth control pills
- ☐ FEMALE: Pregnant

Are you allergic to any medication? If so, please list below.

Do you take antibiotic premedication for your dental visits? If yes, please explain.

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your physician and phone number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications (prescription and non-prescription) including regular doses of aspirin:

Do you currently participate in color code, drug court or a pain management program? * ◯ Yes ◯ No

Are you currently or have you ever taken Boniva, Fosamax, or any other Osteoporosis medication? * ◯ Yes ◯ No

☐ *** By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Verify and Update (If needed)

Personal Information:

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI)

_____
Preferred Name

Title: **Gender:** _____ (Mr/Ms/Mrs/etc) ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____

Prev. Visit: _____

Email Address: _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext)

Best time to call: _____

Address: _____
Address 1

_____
Address 2

_____ (City) _____ (State) ____-____ (Zip Code)

Primary Insurance:

Name of Insured: _____
Last

_____ (First) ___ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

_____

Response Date: _____