WELCOME

Kelley J. Wimmer, D.D.S., P.A.
P.O. Box 187 • Lindsay, Texas 76250-0187
2022 W. Hwy. 82 • Gainesville, Texas 76240
Office: 940-612-4444 • Fax: 940-612-2142
www.wimmerdds.com

1 one ABOUT YOU

Today's Date: _____/_____/_____ File #: _____

Patient Name: _____
LAST FIRST MI

What Your Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate: _____/_____/_____ Age: _____ SS #:_____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext. _____

Other Phone #s: _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

2 two INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's SS #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's SS #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

3 three ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SS #: _____

Driver's License #: _____

Work Phone #: _____

Payment Method: ❑ Cash ❑ Check ❑ Credit Card

_____ _____/_____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
initials

4 four IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Who is your Medical Doctor? _____

M. D.'s Phone #: _____

PLEASE CONTINUE ON BACK

Kelley J. Wimmer, D.D.S., P.A.

MEDICAL HISTORY

Patient Name _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ❍ Yes ❍ No If yes, please explain _____
Have you ever been hospitalized or had a major operation? ❍ Yes ❍ No If yes, please explain _____
Have you ever had a serious head or neck injury? ❍ Yes ❍ No If yes, please explain _____
Are you taking any medications, pills, or drugs? ❍ Yes ❍ No If yes, please explain _____
Do you take, or have you taken, Phen-Fen or Redux? ❍ Yes ❍ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❍ Yes ❍ No _____
Do you take baby aspirin or blood thinners? ❍ Yes ❍ No
Do you use tobacco? ❍ Yes ❍ No
Do you use controlled substances? ❍ Yes ❍ No

Women: Are you

Pregnant/Trying to get pregnant? ❍ Yes ❍ No Taking oral contraceptives? ❍ Yes ❍ No Nursing? ❍ Yes ❍ No

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Local Anesthetics ❑ Acrylic ❑ Metal ❑ Latex ❑ Sulfa Drugs
❑ Other If yes, please explain _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ❍ Yes ❍ No	Diabetes ❍ Yes ❍ No	Hepatitis B or C ❍ Yes ❍ No	Rheumatic Fever ❍ Yes ❍ No
Alzheimer's Disease ❍ Yes ❍ No	Drug Addiction ❍ Yes ❍ No	Herpes ❍ Yes ❍ No	Rheumatism ❍ Yes ❍ No
Anaphylaxis ❍ Yes ❍ No	Easily Winded ❍ Yes ❍ No	High Blood Pressure ❍ Yes ❍ No	Scarlet Fever ❍ Yes ❍ No
Anemia ❍ Yes ❍ No	Emphysema ❍ Yes ❍ No	High Cholesterol ❍ Yes ❍ No	Shingles ❍ Yes ❍ No
Angina ❍ Yes ❍ No	Epilepsy or Seizures ❍ Yes ❍ No	Hives or Rash ❍ Yes ❍ No	Sickle Cell Disease ❍ Yes ❍ No
Arthritis/Gout ❍ Yes ❍ No	Excessive Bleeding ❍ Yes ❍ No	Hypoglycemia ❍ Yes ❍ No	Sinus Trouble ❍ Yes ❍ No
Artificial Heart Valve ❍ Yes ❍ No	Excessive Thirst ❍ Yes ❍ No	Irregular Heartbeat ❍ Yes ❍ No	Spina Bifida ❍ Yes ❍ No
Artificial Joint ❍ Yes ❍ No	Fainting Spells/Dizziness ❍ Yes ❍ No	Kidney Problems ❍ Yes ❍ No	Stomach/Intestinal Disease ❍ Yes ❍ No
Asthma ❍ Yes ❍ No	Frequent Cough ❍ Yes ❍ No	Leukemia ❍ Yes ❍ No	Stroke ❍ Yes ❍ No
Blood Disease ❍ Yes ❍ No	Frequent Diarrhea ❍ Yes ❍ No	Liver Disease ❍ Yes ❍ No	Swelling of Limbs ❍ Yes ❍ No
Blood Transfusion ❍ Yes ❍ No	Frequent Headaches ❍ Yes ❍ No	Low Blood Pressure ❍ Yes ❍ No	Thyroid Disease ❍ Yes ❍ No
Breathing Problem ❍ Yes ❍ No	Genital Herpes ❍ Yes ❍ No	Lung Disease ❍ Yes ❍ No	Tonsillitis ❍ Yes ❍ No
Bruise Easily ❍ Yes ❍ No	Glaucoma ❍ Yes ❍ No	Mitral Valve Prolapse ❍ Yes ❍ No	Tuberculosis ❍ Yes ❍ No
Cancer ❍ Yes ❍ No	Hay Fever ❍ Yes ❍ No	Osteoporosis ❍ Yes ❍ No	Tumors or Growths ❍ Yes ❍ No
Chemotherapy ❍ Yes ❍ No	Heart Attack/Failure ❍ Yes ❍ No	Pain in Jaw Joints ❍ Yes ❍ No	Ulcers ❍ Yes ❍ No
Chest Pains ❍ Yes ❍ No	Heart Murmur ❍ Yes ❍ No	Parathyroid Disease ❍ Yes ❍ No	Venereal Disease ❍ Yes ❍ No
Cold Sores/Fever Blisters ❍ Yes ❍ No	Heart Pacemaker ❍ Yes ❍ No	Psychiatric Care ❍ Yes ❍ No	Yellow Jaundice ❍ Yes ❍ No
Congenital Heart Disorder ❍ Yes ❍ No	Heart Trouble/Disease ❍ Yes ❍ No	Radiation Treatments ❍ Yes ❍ No	
Convulsions ❍ Yes ❍ No	Hemophilia ❍ Yes ❍ No	Recent Weight Loss ❍ Yes ❍ No	
Cortisone Medicine ❍ Yes ❍ No	Hepatitis A ❍ Yes ❍ No	Renal Dialysis ❍ Yes ❍ No	

Have you ever had any serious illness not listed above? ❍ Yes ❍ No _____

Comments: _____

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

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE